THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

AUGUST, 1946

AUG 15 1946

OPERATING ROOMS

Linens

EMERGENCY ROOMS

Linens

PRIVATE ROOMS

Linens

WARDS

Linens

NURSERIES

Linens

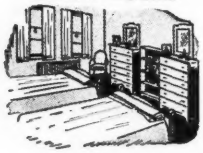
DINING ROOMS

Linens

KITCHENS

Linens

NURSES' ROOMS



Linens

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Every hospital department is vitally dependent on the laundry. Without an ample supply of sterile-clean bed linens, towels, operating linens, doctors' and nurses' uniforms, etc., *no* hospital department can properly function. That's why the laundry department deserves your immediate attention.

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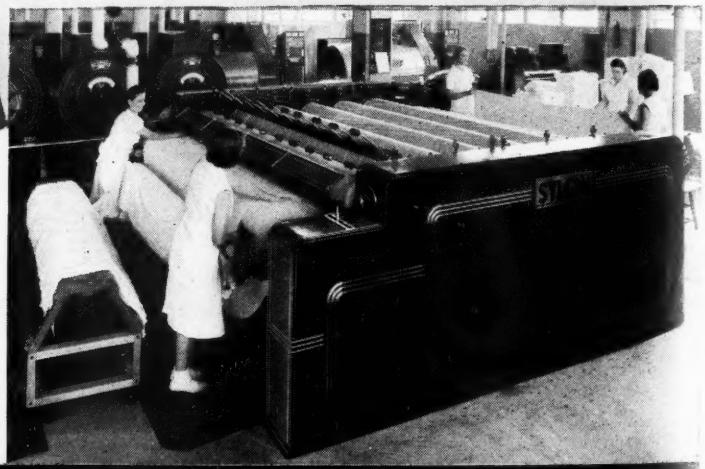

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Contents

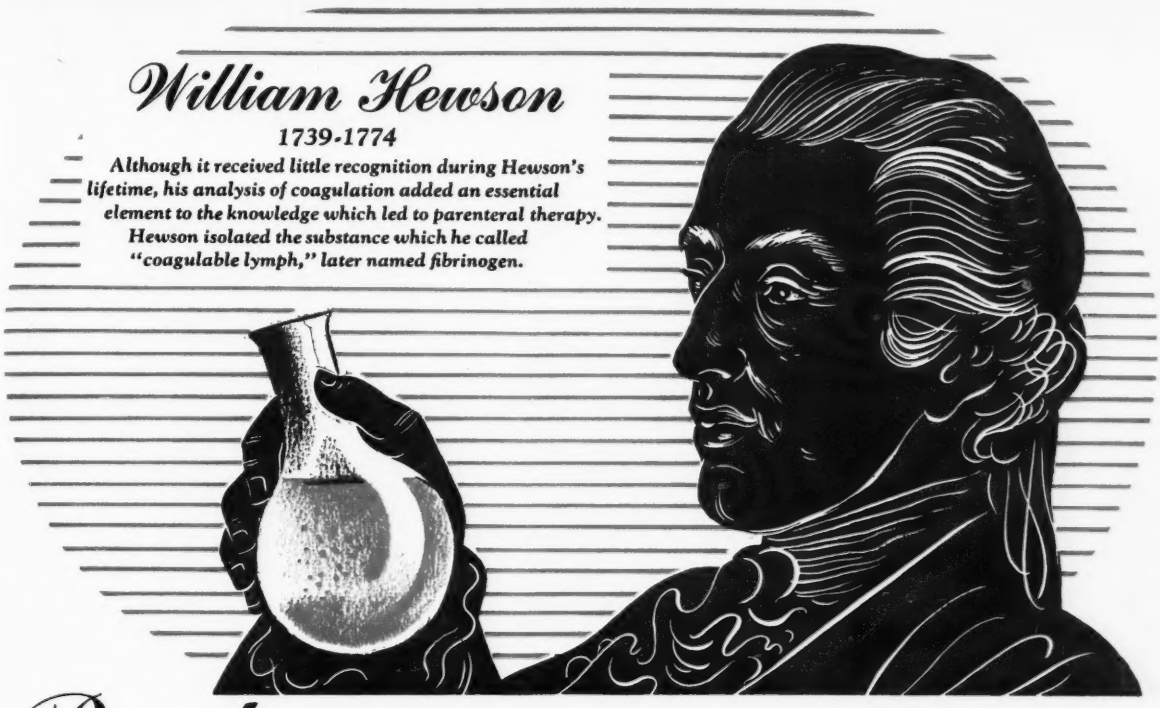
Vol. 23 **AUGUST, 1946** No. 8

PIONEERING THAT POINTS TO *DISCOVERY* . . . *DISCOVERY* THAT *DEMANDS* LEADERSHIP

William Hewson

1739-1774

Although it received little recognition during Hewson's lifetime, his analysis of coagulation added an essential element to the knowledge which led to parenteral therapy. Hewson isolated the substance which he called "coagulable lymph," later named fibrinogen.



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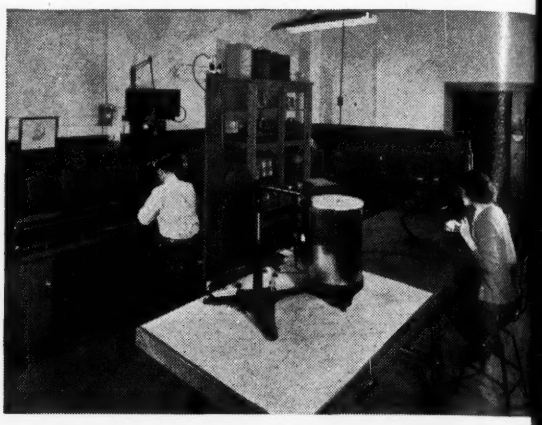
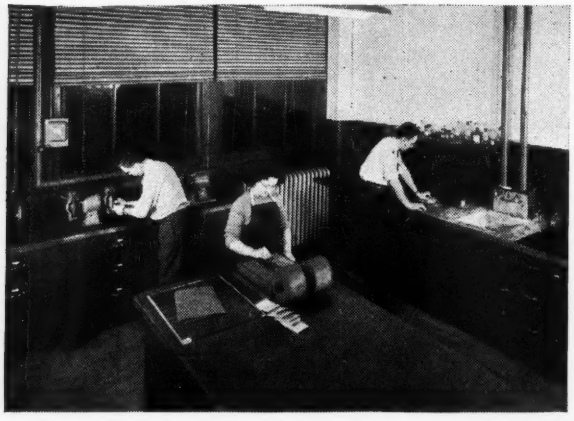
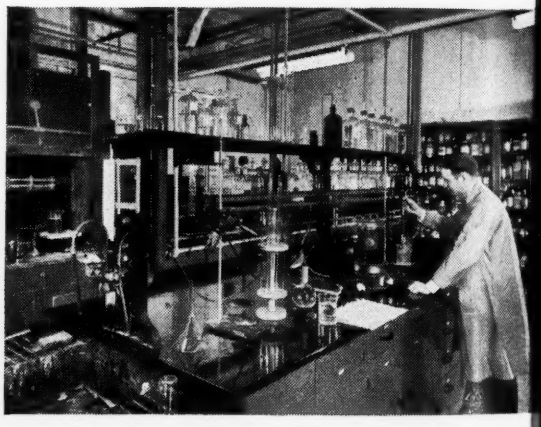


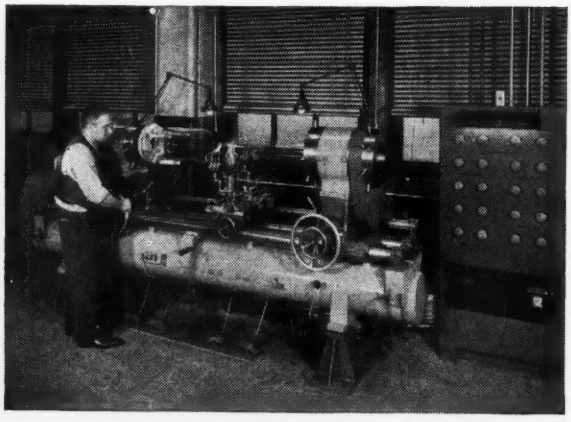
Analytical Section of Metallurgical Laboratory



Preparation Room for Metallurgical Specimens



Chemical Laboratory

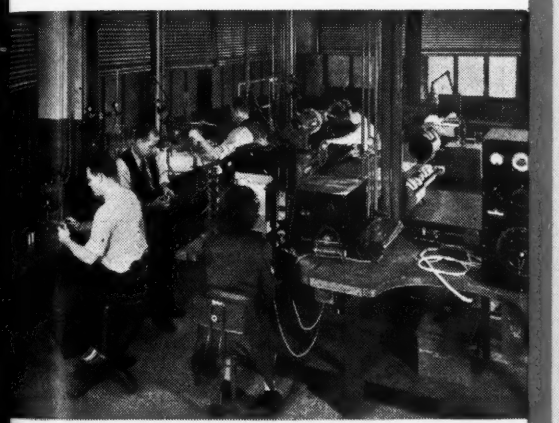


Glass-Working Lathe in Tube Assembly Laboratory

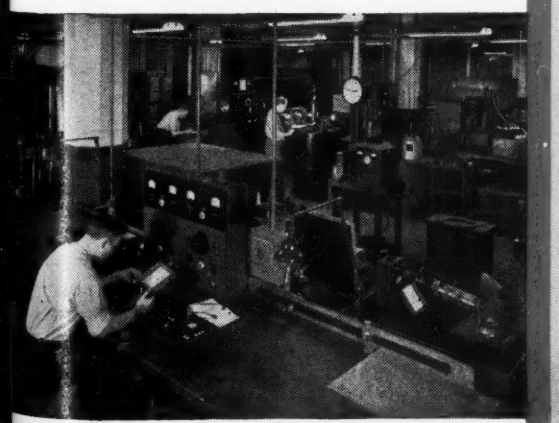
Experimental Machine Shop

G. E. X-Ray's Vacuum Tube Engineering Department functions as intermediary between basic research and practicable adaptability to manufacture

Furnace Room of Metallurgical Laboratory



Tube Assembly Laboratory



Electrical Laboratory

Of paramount interest to radiologists when they learn about an important research development in x-ray tubes, is: How soon will the benefits of this development be made available to the profession?

Few realize, however, that after basic research has worked out a problem to a successful conclusion there is still much to be done before a new x-ray tube is put into production, if it is to fully incorporate the findings of this research and thus assure the anticipated advantages.

It is during this period between basic research and manufacture that G. E. X-Ray's Vacuum Tube Engineering Department assumes a highly important role. Conveniently segregated in a single floor space of 12,000 square feet, the engineers and physicists of this department are equipped with the most complete facilities for all phases of development, design and engineering as they pertain to x-ray tube manufacture. Having available every type of equipment as used in actual manufacture, with adequately equipped chemical, metallurgical, and physics laboratories, this group of experts has the means for determining experimentally the possible problems of manufacture, and also how to circumvent them. Thus is eliminated the radiologist's own laboratory as a proving ground to reveal otherwise unforeseen deficiencies in design or manufacturing processes.

Continuously, the G. E. organization's aim is not only to develop new Coolidge tubes with which to further advance the science of radiology, but also to build them better and better, for ever-higher operating efficiency and a longer life of service which makes them more economical to use.

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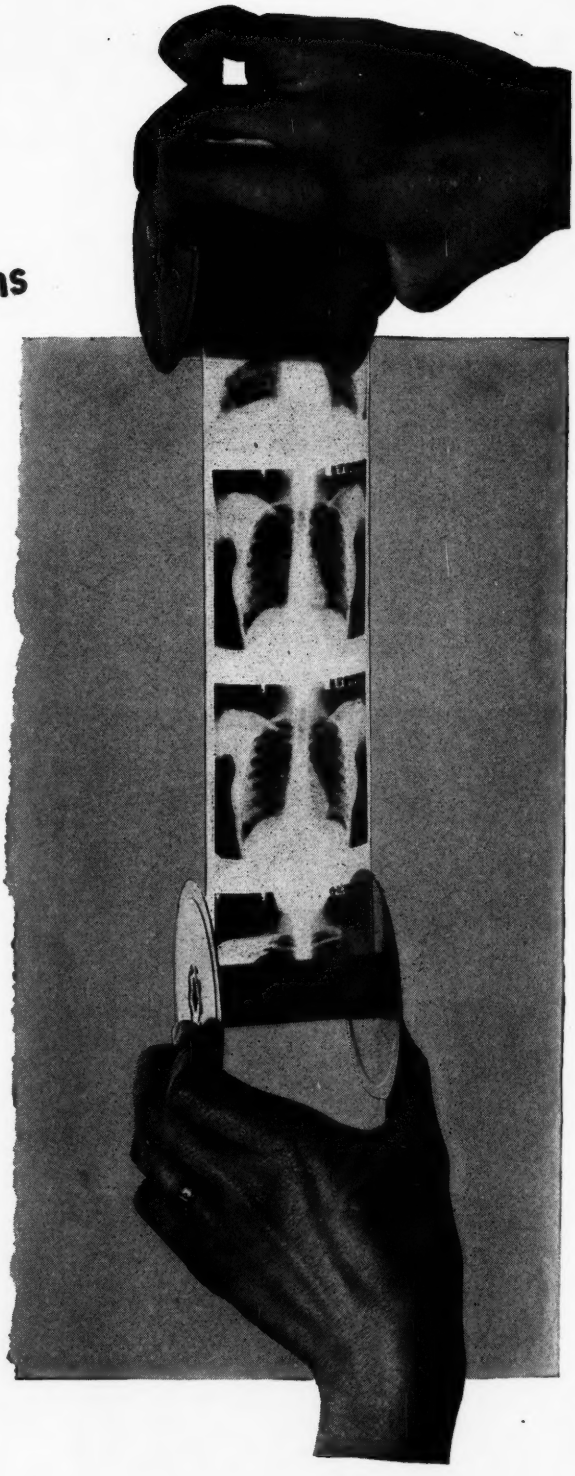
use this quick, economical method

to screen hospital admissions

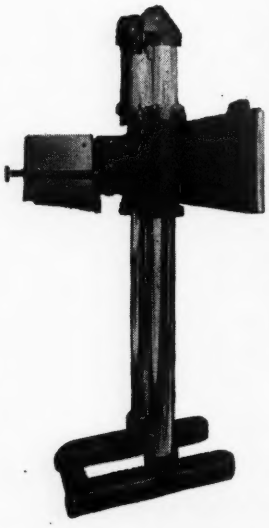


Miniature photofluorography offers hospitals quick, economical help in screening hospital admissions. These routine miniature films enable the radiologist to determine which incoming patients require more thorough chest examinations. Used as a routine hospital admission tool, photofluorography accomplishes three important objectives:

1. Supplies an economical means of determining which admissions require complete chest scrutiny.
2. Recruits patients who might not otherwise receive this examination.
3. Provides accurate telltale signs over and above clinical history and initial physical examinations.

While miniature film methods do not supplant established practices in chest diagnosis, they do perform an important service in augmenting laboratory procedures. Photofluorography need not place heavier loads on the radiological staff. The time needed to read miniatures is minimized, for the chest is either negative or needs standard 14 x 17 radiography for extensive examination.

Write your nearest Ferranti office for complete details on the advantages of miniature photofluorography for hospital admissions.



Westinghouse stationary photofluorograph used in radiographic room and utilizing available generating apparatus.

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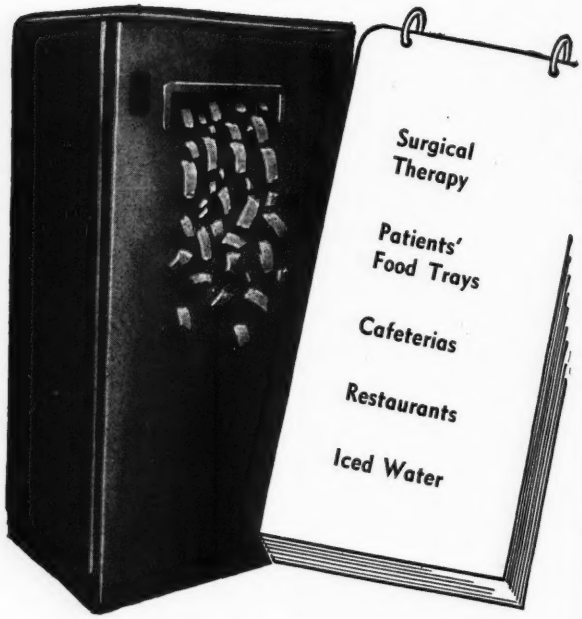

IF YOU ARE—YOU NEED

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HERE ARE sparkling Flakice Frosty Ribbons — the new "tailor-made" ice that is so much more effective and economical than ordinary crushed or block ice. Notice how closely it packs . . . how clean and attractive it looks! This is the way it comes from the Flakice Machine — all ready for use without crushing or cutting.

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Across the Desk

By C. A. E.

New Directors of Hygiene Products Ltd.

Mr. T. R. Daykin, President of Hygiene Products Limited, Montreal, recently announced the appointment of two well-known Canadians to the board of this company. Mr. Kenneth A. Wilson, K.C. (right), is a partner in the law firm of Robinson, Wilson & Johnson, Vice-President and Director St. Lawrence Steamships Limited, Vice-President and Director Morris Lumber Limited.

Mr. F. T. W. Saunders, O.B.E. (left), is a Fellow of the Institute of Costs and Works Accountants (Breat Britain) and was formerly Managing Director of Fry-Cadbury Limited, Montreal. He was associated with the latter company in both England and Canada for many years.

* * * *

New Tile Flooring Industry for Canada

Announcement was recently made by Mr. John G. Kent, Vice-President and General Manager of Armstrong Cork and Insulation Company, Limited, that a complete line of Armstrong's Asphalt Tile Flooring will be manufactured for the first time in Canada in their new plant, now under construction in a new industrial section of Montreal.

Up to now, all Asphalt Tile sold in Canada by "Armstrong Cork" was made in the United States, but the wide acceptance and demand for this product has made its production in Canada both feasible and desirable. Thus Armstrong Cork will be helping to introduce a new industry to Canada's growing industrial picture.

(Continued on page 16)

Precision Counts . . .

In every line of scientific endeavour there is a constant demand for any device which will reduce or eliminate the margin of error. Digoxin, a pure crystalline glycoside, * provides the medical profession with just such an aid. Because it is a definite chemical substance, constant in composition and uniform in potency, it can be prescribed *with precision* in terms of weight of the pure drug, and its results accurately predicted. Literature on request.

* Isolated from the leaves of digitalis lanata by the Wellcome Chemical Works (England).

For oral use: 'Tabloid' BRAND Digoxin 0.25 mg (gr 1/260 approx.) Bottles of 25, 100 and 500.
Solution of Digoxin (B.W. & Co) 0.5 mg (gr. 1/130 approx. in 1 c.c. Bottles of 30 c.c.

For parenteral use: 'Wellcome' BRAND Injection of Digoxin 0.5 mg (gr. 1/130 approx.) in 1 c.c. Boxes of 12, 100.

DIGOXIN

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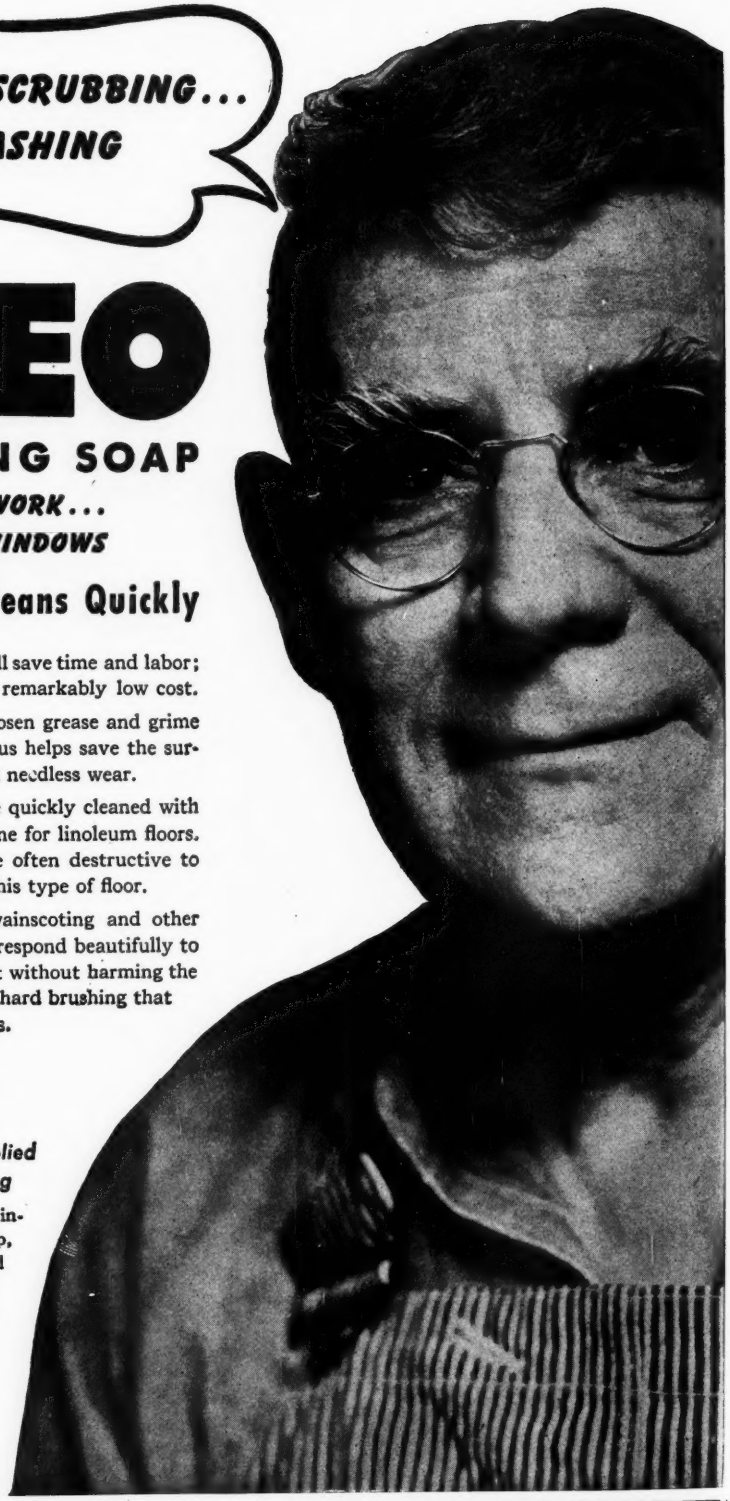
IT'S GREAT FOR SCRUBBING... MOPPING... WASHING



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FOR FLOORS... WOODWORK... PAINTED WALLS AND WINDOWS

Mixes Instantly • Cleans Quickly

Here is an all-purpose general cleaner that will save time and labor; do many maintenance jobs well and at a remarkably low cost.

● Zoleo softens encrusted dirt, tends to loosen grease and grime without scrubbing or hard brushing and thus helps save the surfaces on which it is used from scratches and needless wear.

● Wood, cement, tile or terrazzo floors are quickly cleaned with Zoleo and its oil base makes it especially fine for linoleum floors. Whereas harsh alkali chemical cleaners are often destructive to linoleum, Zoleo actually helps to preserve this type of floor.

● Woodwork, painted walls, stair-rails, wainscoting and other inside trim are easily cleaned and windows respond beautifully to Zoleo treatment. Because Zoleo cleans paint without harming the paint it is ideal and eliminates the need for hard brushing that might mar the painted or varnished surfaces.

KWYKWAX

Economical Way to Wax Your Floors—Applied with a Mop... No Rubbing... No Polishing

Floors, Woodwork and Furniture are easily maintained with KWYKWAX on a lamb's wool mop, cheese cloth mop or string mop and no skilled operator nor heavy and expensive waxing equipment are necessary . . . KWYKWAX dries with a gloss and does away with buffing and polishing. In less than 20 minutes after application KWYKWAX is dry and ready for traffic! SAVE TIME . . . SAVE LABOR . . . SIMPLIFY MAINTENANCE . . . with KWYKWAX.

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OFFICE BUILDINGS
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Across The Desk

M. C. Wilt President of Curtis Lighting

Melvin C. Wilt, President of Curtis Lighting of Canada, Limited, was elected President of Curtis Lighting, Inc., the Chicago parent company, at the last meeting of the Board of Directors. Mr. Wilt continues as President of the Canadian Company.

Mr. Wilt started with Curtis in 1928, as a Sales Representative for Cleveland, Ohio, territory. He moved to Toronto, Canada, in February, 1931, to set up and organize Curtis Lighting of Canada, Limited. After serving as Managing Director for ten years, he returned to the United States Company as Vice-President and General Manager.

M. C. Wilt's election marks the first time that the position of President has been held by any other than a member of the Curtis family.

* * * *

War or no War . . . Celiac Babies Got Bananas

Throughout the war celiac babies were provided with their needed quota of bananas. At the request of the United Fruit Company, the banana jobbers set aside a portion of their scant supplies to take care of the needs of celiacs and others for whom doctors prescribed bananas. Even during acute shortages, holders of certificates from physicians prescribing bananas were able to get them.

Ever since the discovery by the medical profession 20 years ago that the carbohydrates in the fully ripe banana are well tolerated and utilized by infants and children suffering from celiac disease, bananas have been prescribed by doctors as a definite part of the dietary regimen for celiac patients.

The banana contains adequate pectins, and its fat content (.2%) is almost negligible. It also has a plus value from the nutritional standpoint because it is a good source of vitamins and minerals.

* * * *

A lady psychiatrist questioning a patient: "What would you say would be the difference between a little boy and a dwarf?" The patient thought a while and said, "Well, there might be a lot of difference." "What, for instance?" asked the psychiatrist encouragingly. "Well", replied the patient "the dwarf might be a girl."

(Concluded on page 20)

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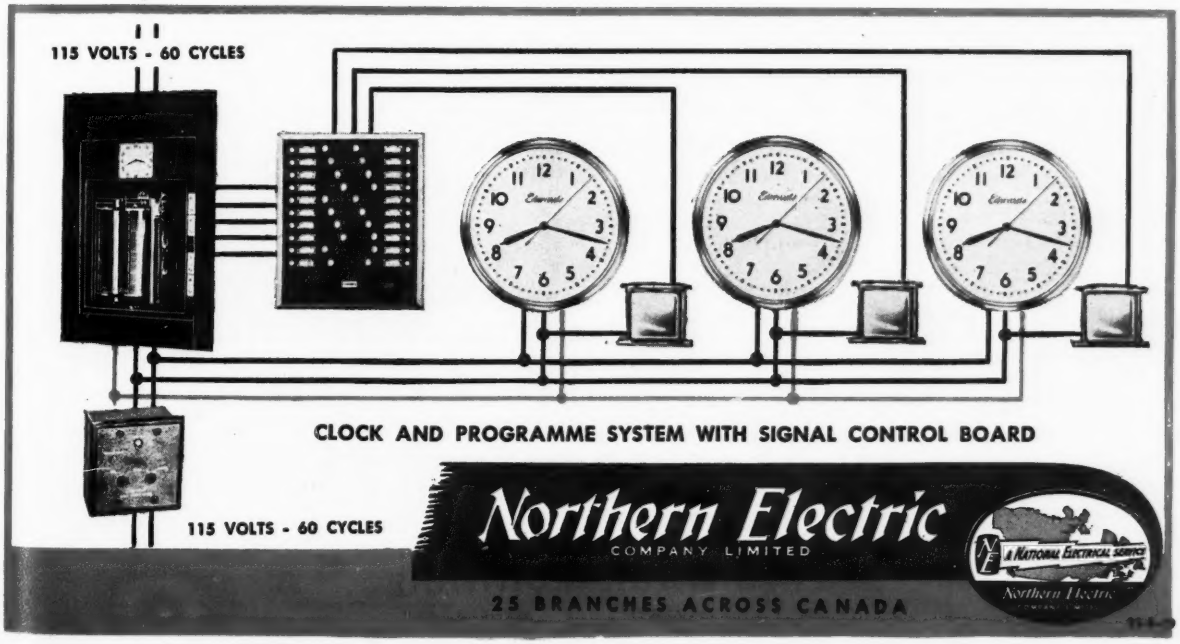

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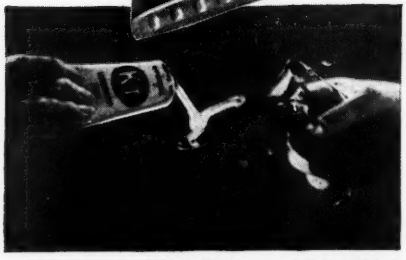

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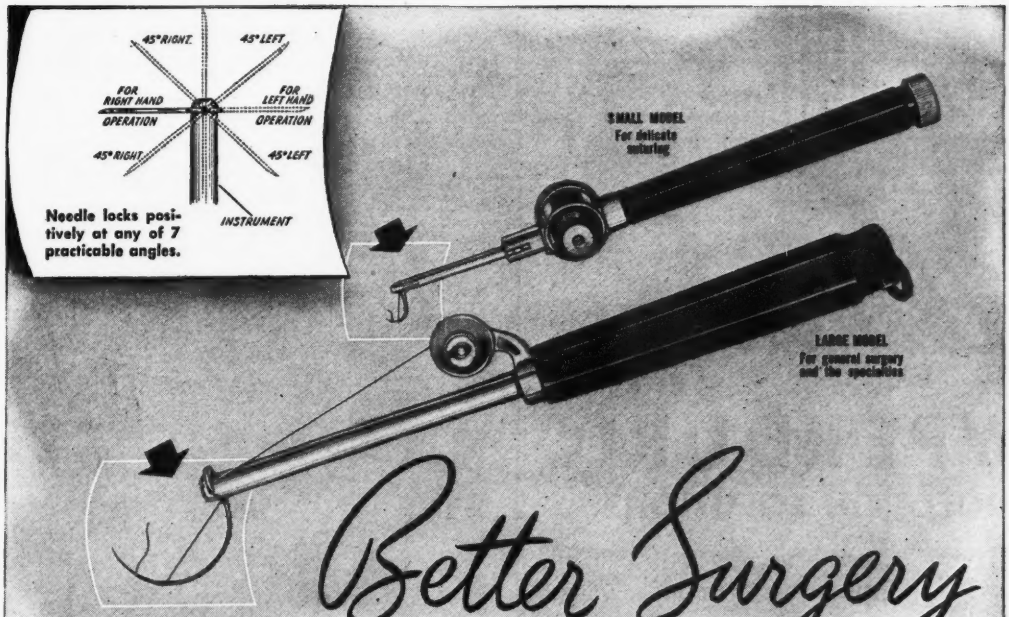

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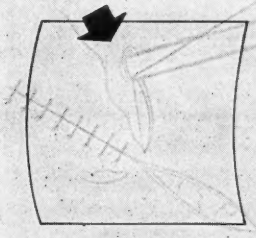

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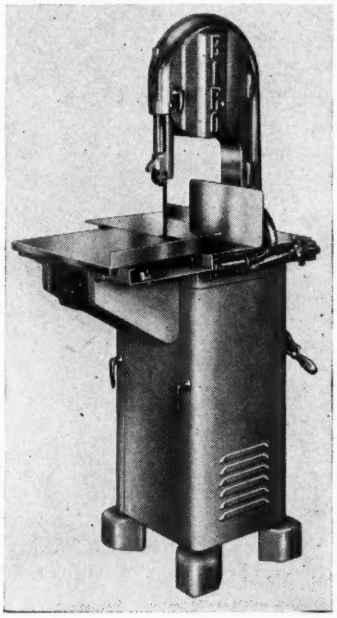

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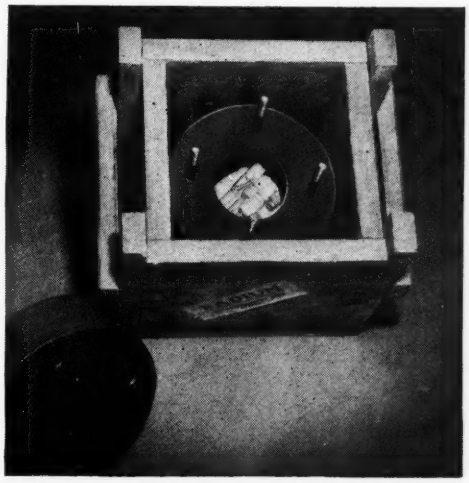

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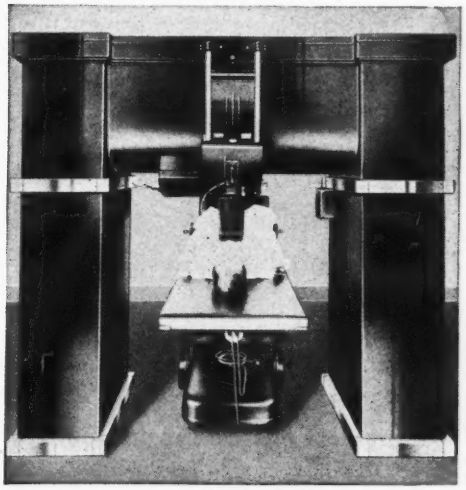

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An authoritative statement of the reliability of 'Dettol' in destroying streptococci on the hands

Writing in the British Medical Journal (2.725) the eminent bacteriologist Leonard Colebrook says of ' Dettol ' Antiseptic :

' The most reliable procedure for the complete elimination of streptococci from the naked ' hands is as follows. Wash for one to two minutes in a pint of warm water, using plenty of ' yellow bar soap and a nail brush to the nail sulci ; then pour into the palm of one hand ' a teaspoonful of neat Dettol . . . and work into the skin of the hands till dry (one to two ' minutes).'

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applicable, without causing injury, to raw wounds and surfaces; which does not inhibit the natural processes of repair; which is stable at all clinically desirable temperatures and at all dilutions; which is non-staining, agreeable in use and pleasant to smell.

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* *Colebrook, L. J., Obstet. & Gynaec. of Brit. Emp. Vol. xliii., No. 4, 1936.*

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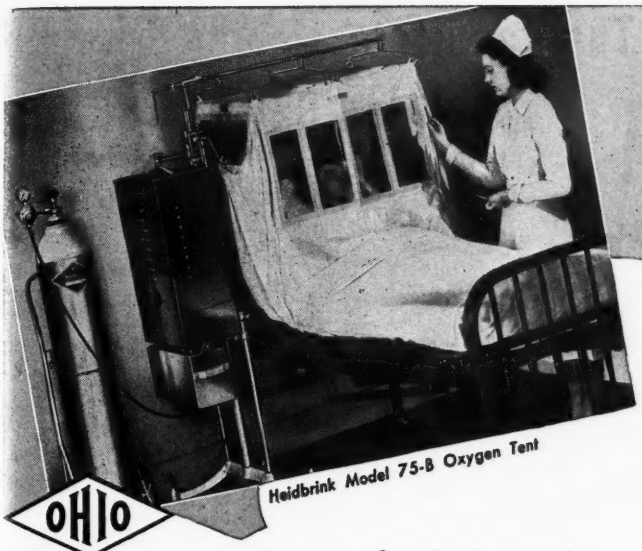

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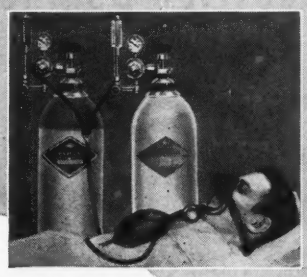

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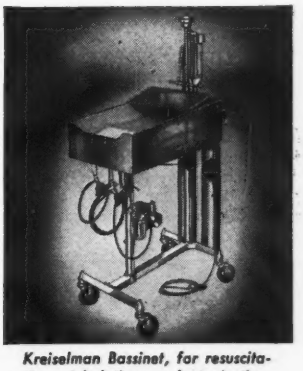

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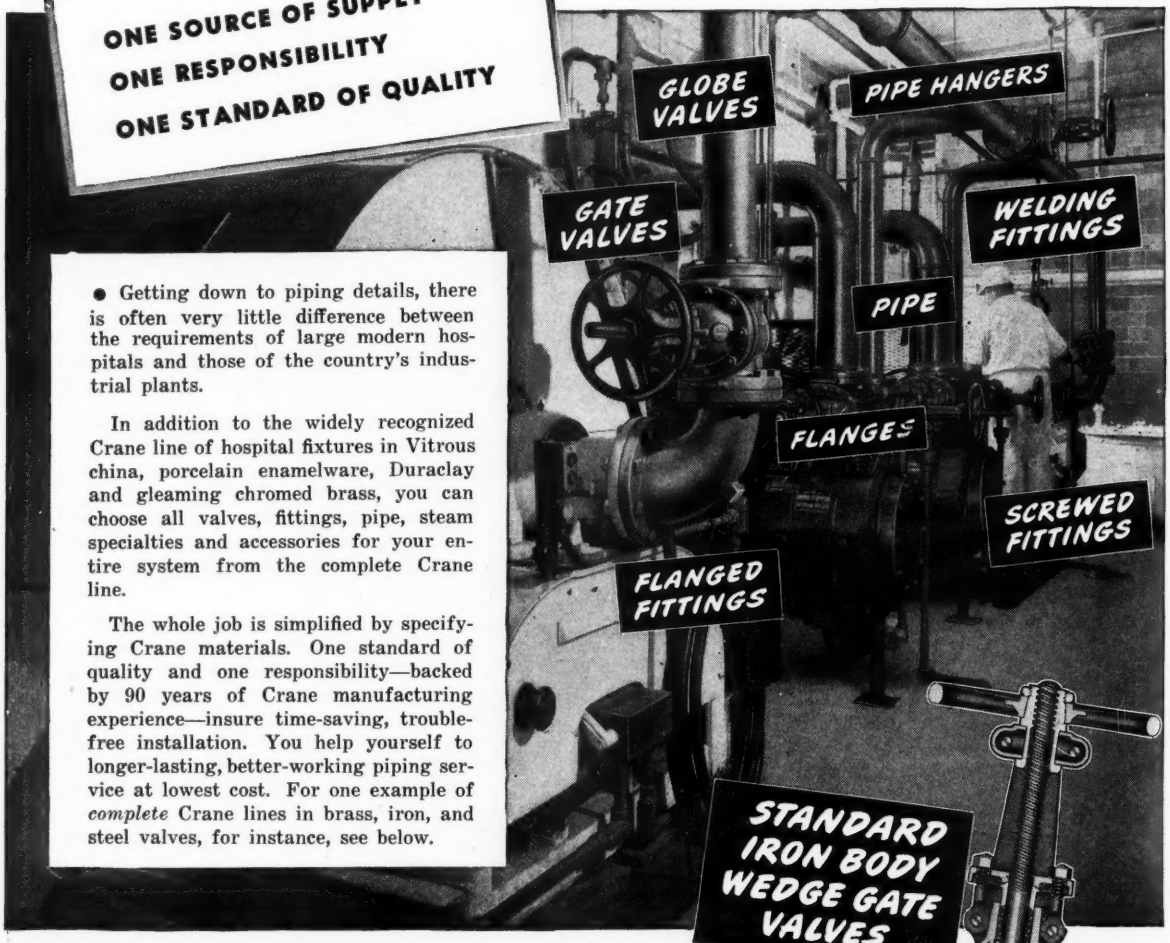

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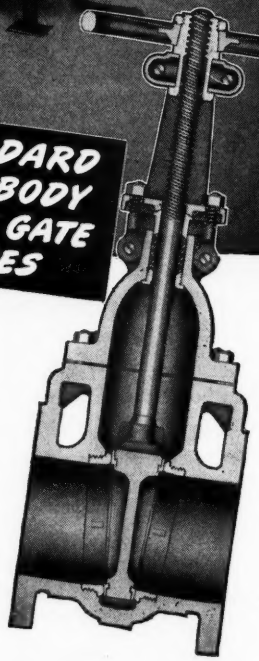

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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, August, 1946 Vol. 23 No. 8

Should There be PRIORITIES in SOCIAL LEGISLATION?

IN what order of precedence should health and social security measures be developed? This is an important consideration to-day. Although group pressure (or lack of it) ranges all the way from the barest minimum of public health care to a complete taking over by the state of the individual's body, soul, mind and pocketbook, it is becoming apparent, as we get down to the practical factor of cost, that these developments must be taken a step at a time and that some factors in health and social protection are more urgently in need of attention than others.

Marsh Proposal

Speaking in the House of Commons in April (Hansard, 16, p. 597) the Honourable Mr. Claxton stressed the importance of the order of priority of various proposals. He quoted the report of Dr. L. C. Marsh which recommended the following order:

1. Unemployment insurance.
2. Health insurance.
3. The disability—old age—survivors group of insurances.
4. Children's allowances.
5. Sickness cash benefits.
6. Funeral benefits.

President Truman's Plan

Mr. Claxton also referred to President Truman's masterly message to Congress last November in which he proposed this order:

1. Construction of hospitals and related facilities.
2. Expansion of public health, maternal and child health services.
3. Support of medical education and research.
4. Prepayment of medical costs (our own files list this one as "national compulsory medical insurance").
5. Protection against loss of wages from sickness and disability.

It will be noted that Mr. Truman puts major emphasis upon preventive and curative health care and less upon the maintenance of income. The Committee on Medicine and the Changing Order of the New York Academy of Medicine endorses these points outright or in principle except for Number 4, to which it is opposed. It proposes instead that voluntary non-profit insurance be given a thorough trial, that compulsory government insurance be tried only at state and local levels, that group practice be extended and that basic public health services be extended where needed.

Government Viewpoint

On that occasion the Honourable Minister set forth what may logically be considered as the Government policy:

1. The prevention of illness and the cause of disability through disease and accidents. For these purposes a very wide measure of grants to the provinces has been proposed.

2. Treatment—to be provided through health insurance.

3. Rehabilitation through vocational training, etc. Rehabilitation by D.V.A. is an example.

4. Sickness or invalidity benefits. This is one of the most difficult items to administer and is placed after health insurance because only when there is a nation-wide system of health services providing care for the whole population can one "properly deal with the class of people who do not respond to treatment and who remain incapacitated."

C.M.A. Recommendations

In this connection, it is of interest to note that last year the Committee on Economics of the Canadian Medical Association proposed to the Federal Government the order in which that body considered various developments should take place. These are as follows:

1. A preventive program—communicable diseases; sanitation; prenatal, postnatal, infant, pre-school and school health supervision.

2. Provision of medical and allied services for remote areas.

3. Adequate diagnostic facilities, especially in rural areas.

4. Adequate hospital facilities, including construction and operational assistance, adequately trained personnel and the provision of chronic, convalescent and special as well as active treatment hospitals.

5. Full coverage for the welfare group—indigents, mothers' allowance recipients, blind and old age pensioners.

6. Educational program—for the public and for the profession, graduate and undergraduate.

7. Improved standards of living—environment conditions, security against fear and want, adequate nutrition, education, exercise and leisure.

Obviously these different listings are the result of varying angles of approach to the subject. They do agree in a broad measure, however, in the necessity of providing adequate preventive and curative health care, the main difference being in the manner of applying these services and in the inclusion of monetary aid. One notes a difference, too, between the socialistic viewpoint, the practical viewpoint and that of those who render the services. The general acceptance of some reasonable order of priority, toward which to work as national and provincial finances permit, would simplify greatly the problem before our legislators.

Inaccurate Publicity on Nurse Shortage Deplored

"Much of the publicity which has been given over the past few months on the shortage of nurses in hospitals has conveyed to the public an entirely wrong impression of the situation," stated Mr. Arthur J. Swanson, President of the Canadian Hospital Council at the meeting of the Maritime Hospital Association at Digby, N.S. "It would seem that certain speakers have been stressing conditions pertaining to hospital employment which had been mentioned in a report on nursing service published some seventeen years ago and which have long since been corrected, certainly in the larger hospitals and more or less generally in the others; so we must look for other reasons for the difficulty in securing adequate number of nurses for the requirements in civilian hospitals".

In view of the many misleading statements which have received widespread publicity, Mr. Swanson stated that a joint committee of the Canadian Nurses Association and the Canadian Hospital Council had expressed the hope that the Provincial Nurses Association and the Provincial Hospital Association in each province would secure accurate factual data and would bring this true information to the attention of the public, not only by editorial comment but by paid advertising.

Factors causing the present shortage are:

1. The large number of nurses who have been in the armed forces and are not yet available.
2. The number still required by Military and D.V.A. hospitals.
3. The number employed in expanded public health programs.
4. The number employed as industrial nurses and in other capacities.
5. The increased demand for special duty nurses.
6. Dissatisfaction with the hours of duty and pay of general duty nurses.
7. Shortage of other personnel, thus imposing an increased burden on the nurses.

An Unsound Situation

"Many of the organizations making the greatest demands for nurses", stated Mr. Swanson, "are organizations which do not contribute in any way towards the training of nursing personnel. The hospitals are the only source of supply for training nurses. This is a very unsound arrangement, because, irrespective of any idea that may be in the public mind, the operation of a training school is not a source of cheap labour; it is a costly item in any hospital budget, for we must maintain and give these girls a costly nursing education for three years. It is true that they do devote certain time to ward activities but this is all in the way of practical training and the hospital makes a very definite financial outlay to house, feed, clothe, educate and supervise the work of these trainees in an adequate manner. In addition the hospitals provide, by means of scholarships, opportunities for some of the best girls on graduation to proceed with post-graduate training along the lines in which they are interested. It seems unfair that since these girls have received their training in the hospitals, and in many instances post-graduate training, they should be absorbed by outside bodies, organizations which have made no contribution whatsoever to their training and who are able in some instances, by virtue of being governmental bodies, to pay higher salaries than it is possible for hospitals to pay under the present method of financing."

The Care of the

Chronically Ill Patient

R. P. VIVIAN, M.D.

Strathcona Professor
of Health and Social Medicine
McGill University, Montreal.

THE chronically-ill and the incurable patient constitute a major problem. The increasing number of families living in apartments or under crowded conditions, the almost complete lack of domestic help, and the deficiencies in visiting-nurse service have all created a greater need for institutional care for these patients. The lack of suitable accommodation elsewhere has resulted in a large number of these patients being cared for in public general hospitals. The serious result is that the general hospitals are now obliged to delay service to the more acutely ill and to strain all their resources in carrying this additional load.

The results are clearly shown in a recent survey (December, 1945) of seven of the English-speaking hospitals in Montreal. The total bed accommodation of these hospitals is 2,449. The total admissions in one year (1944) were 47,946, giving an average day's stay per patient of 13.9 days. If patients could be discharged from these public general hospitals after a maximum stay of sixty days, 37,256 days' care would be saved, releasing 102 beds and permitting the admission of 2,874 more patients.

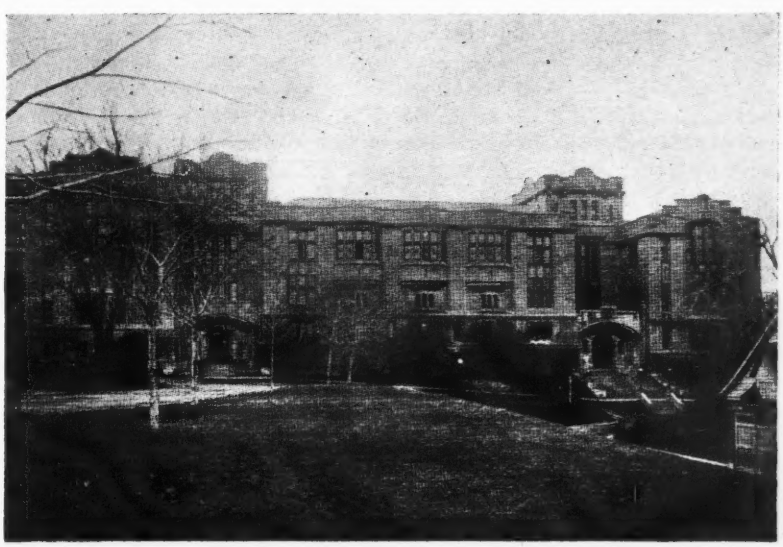
If the chronically-ill patient is to be discharged from active treatment at the end of sixty days, some other type of care must be provided. A number of patients will require some continuation of treatment which should be given in close association with a public general hospital. There are many who could be discharged to institutions providing nursing care and medical supervision if such institutions existed in greater numbers. Some could be well cared for in suitable boarding-homes or even in their own homes if other facilities for service could be made available.

Mental Patients

This group of patients represents, however, only one portion of those classified as chronically-ill. Another group is found in the overcrowded conditions of mental institutions. It is not the purpose of these remarks to cover the problem of mental illness, but mention should be made in passing that attention should be given to the care of the arteriosclerotic and senile dementia cases on some other basis than presently in vogue. Psychiatric service could be greatly improved if such recognition were translated into action.

The Solution

The solution of the problem under discussion would seem to lie in the provision of a limited number of beds for the long-stay patient in special accommodation within a public general hospital. This accom-



Medical Building, McGill University, Montreal

An address at the March Regional Meeting of the American College of Surgeons, in Montreal.

modation should be separated from the general activities and expenses of the hospital which provides facilities for the treatment of the more acutely ill. This should have the effect of freeing the major portion of the cost of ancillary services from the per diem rate, creating lower-priced accommodation than can at present be made available in the public general hospitals. It is imperative that additional institutions be established to provide nursing care and medical supervision. These could be constructed at considerably less cost than public general hospitals. It is difficult to attract voluntary funds for the construction of institutions for the chronically ill. A substantial portion of the cost of construction will need to be obtained out of tax-collected funds from appropriate levels of government. In my opinion, the management of the hospital should be left to a voluntary group so that the hospital may have the benefit of organizations such as women's auxiliaries. These auxiliaries contribute a great deal in added comforts for patients and stimulate a good type of management.

In smaller communities or in certain portions of larger ones supervised boarding-homes could be of great help. The experience with boarding-homes in the past has frequently been unfortunate because of inadequate supervision, the absence of suitable medical control and the difficulty of obtaining enough money for maintenance. The problem of maintenance is also a very real one either in the public general hospital or in an institution providing care for the chronically-ill. The required length of stay and the economic status of the majority of patients mean that they cannot finance themselves, and the strain is usually too heavy to be continued for very long by their families.

Care in the home might be achieved in many more cases if a tax-supported visiting-nurse service and some domestic assistance were made available.

Adequate care for the chronically-ill and incurable patient will remain a problem until such time as governments are prepared to pay the full per diem cost of care. In this, the tax-payer must be protected through uniform cost accounting systems under government supervision.

The answer to the problem of care for the chronically-ill and incurable patient does not lie merely in the treatment, such as it is, of existing cases. We must take into account the ways and means of achieving a better method by which more of these cases can be prevented through the establishment of a comprehensive program in Public Health and Social Welfare.

Voluntary Medical Care Plans

In the U.S.A., twenty-five states out of forty-eight now have one or more voluntary medical care plans in operation.

There are county plans, city plans, area plans and state plans; and while they vary widely in some ways, they are quite similar in their basic characteristics. For the most part they provide only in-hospital surgical and obstetric coverage, although benefits for x-ray and anaesthesia are frequently included. A small number of plans include all services, medical and surgical, in or out of the hospital. A popular benefit is in-hospital medical care. The plans are similar in that all have free choice of physician, all are voluntary and, with few exceptions, include the entire family. The principle of allowing subscribers to continue the contract after leaving the group has been generally accepted. A pre-existing condition clause is found in some contracts.

The most popular type of plan is a combination service-idemnity plan in which subscribers earning less than a given amount may not be charged an additional fee by doctors. When the subscriber's income is above the stated limit, the doctor is free to charge an additional fee.

In most areas medical care plans work with Blue Cross. Thirty-one of the fifty-three plans are co-ordinated with the hospital care plans. Eight of these are operated under single boards of trustees and the hospital service corporation offers both contracts. In the other twenty-three, the medical and hospital groups have separate corporations, each controlled by their respective professions but the hospital plan participates in or handles entirely the administration, usually on a contract basis.

—Public Health Economics.

Chicago Institute in September

The American College of Hospital Administrators announces that plans are being completed for the fourteenth Chicago Institute for hospital administrators to be held at International House, University of Chicago, September 16-26.

The Institute presents a survey covering all aspects of hospital administration, emphasizing particularly those portions which are most pertinent at this time. An effort is being made to plan the course so that it will be especially helpful to those administrators who are seeking an over-all review of hospital administration.

Under the directorship of Dr. Malcolm T. MacEachern, the Institute offers a practical program dealing with present-day problems. Recognized authorities in the hospital field will be in charge of the lectures and seminars. Practical demonstrations will be held in hospitals in the Chicago metropolitan area. Registrants will have ample opportunity to present problems for group discussion in the round tables and conferences.

The registrants will be housed and the program held at International House which is situated on the north side of the Midway at 1414 East 59th Street. This is a most unique building and is ideally equipped for institute purposes, containing as it does living quarters, class rooms and dining halls.

Registration for the Institute is open to men and women who hold the position of administrator or assistant administrator of a hospital. Applications will be considered in the order in which they are received. Registration fee for the 12 day session is $20. Application blanks and further information may be obtained by writing to Dean Conley, executive secretary of the American College of Hospital Administrators, 18 East Division Street, Chicago 10.

Small Hospital Plans

made available by

Saskatchewan Government

TO assist the many communities in Saskatchewan planning to build local health centres and hospitals, the Health Services Planning Commission of the Department of Public Health has had standard plans and specifications for such hospitals prepared and is making them available free of charge.

Providing for hospitals ranging in size from 10 to 20 beds, the plans will save communities between $1,500 and $3,000 in their building costs. In addition, the plans were prepared in consultation with medical and nursing authorities and reflect the most up-to-date thinking of rural health experts. The exterior of the buildings are of modern and functional design which will add attractiveness to any community. Besides obtaining the plans and specifications, communities may consult the Regina architectural firm which executed them, Portnall and Stock, regarding specific sites and modifications to meet local needs . . . also free of charge.

Illustrated here is the ground floor plan and a sketch of the 15-bed health centre and hospital. The hospital can be increased in size merely by extending the hospital wing, which can be done at any time after the original building is completed and without major alterations. Thus it is possible for communities to build for current needs while enabling them to expand to meet greater needs in the future. The basic design remains the same for all sizes.

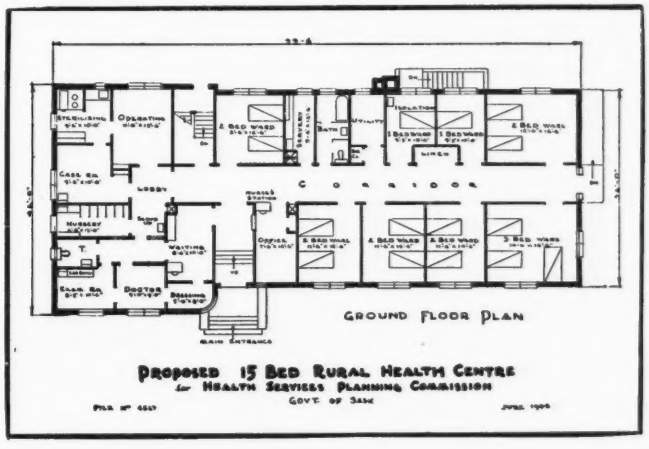
The plans are arranged so that the wards are segregated in one area and the business, operating and health centre space in another area, thus affording the greatest amount of privacy to the hospital section.

All services have been maintained on one floor level, with the exception of kitchen and laundry facilities which are located in the basement. This will decrease the nurses' work. Space is provided for doctors' offices with adjacent waiting room, examination room and dressing room with toilet facilities. The operating group consists of operating room proper, case room and sterilizing room. The nursery is complete with equipment for bathing babies and supply cupboards, and is so arranged that compartment cubicles may be provided for segregation of cribs.

The ward layouts are based on one- and two-bed wards for maximum use, and three-bed wards are incorporated in the fifteen- and twenty-bed plans. Ward areas are provided with servery, utility room and toilets.

The basement area is not completely filled, which will allow for individual use of this space by local hospital boards.

Two types of construction are called for; one being frame and stucco finish and the other being frame and brick veneers. Walls and ceilings in both types of construction are insulated. The heating system is of hot water type, with radiators wall-mounted for cleanliness. Provision is made for stoker firing of boilers. All walls will be plastered and all baseboards coved or rounded to facilitate cleaning. Floors will be covered with linoleum or tile.



Fundamental Difficulties Facing

Health Insurance

Essential steps to a solution outlined by one whose plain speaking is based on experience

J. A. HANNAH, B.A., M.D., C.M.
Toronto

IT is impatience with humanity's slowly moving mentality which drives the general public to put pressure on our governments for security at any price. This urgency has caused all studies we have seen so far to miss entirely the basic problems involved. They have sought to take the "short-cut" to mass "social security" at the expense of "personal liberty". As history has shown, there is no security of any kind in this direction. Unfortunately, the various bodies intimately associated with the problem have fallen into the same error. They fail to realize that their proposals endanger the very elements which they as individuals hold essential and basic to their own and their profession's welfare.

Our experience indicates that unless any plan for health insurance, whether it be Dominion, Provincial or local, grows gradually and on the basis of experience, it is doomed to insolvency. In fact, we believe that health insurance is of such a nature that a complete coverage on a wide basis is economically unsound under existing circumstances. We do not mean to say that a start cannot be made. We do say, however, that on a Dominion or Provincial basis, until such time as we gain sufficient experience and can train personnel, it will be necessary to limit medical coverage to catastrophies costing more than a minimum of approximately $25.00. Alternatively, a simplified and better organized method of providing medical care would make it possible to give complete service. So far nobody has tackled the problem from this angle.

Associated Medical Services started on a very broad basis, including everything from office and home calls to major operations, and such hospitalization as was necessary for the condition under treatment. Private duty nursing in the home as well as the hospital was also included. In 1942, we were forced to eliminate some of the services which could not be controlled and set definite limitations on certain conditions such as obstetrics. This adjustment checked an unfavourable economic trend attributable in large part to abuse or what is known in the vernacular as "chiselling".

It is still apparent that we have not yet reduced our services to a basis which is economically sound. During 1945, we spent $123,000 on administration. Of this amount, we spent at least 50 per cent or a total of $61,000 to administer accounts of less than $10.00. This amounts to approximately $2.00 per subscriber per year for administration which is much more costly to the subscriber than if he paid directly. This, however, is not the worst feature. Despite our best efforts to control abuses, the administration estimates that at least $100,000 was spent in minor items which did no one any good insofar as their health is concerned. In all, it is felt that an average of at least $5.00 per subscriber per year is wastefully spent through abuse and an endeavour to control it.

To us it appears that we cannot change human nature. Insurance generally has known for a long time that the easier it is to reap benefits from insurance the greater will become the demand for benefits. In the vernacular, "insurance is fair game". When an individual deals with a common fund there is a tendency to develop an "elasticity of conscience" which would be construed as dishonesty if he were dealing with another individual. It is therefore necessary to find a solution to the problem of health insurance in which there would be a minimum of opportunity to exercise this elasticity of conscience.

The first principle which must be observed is that each economic class should be given as much but not more economic assistance than is required for their basic needs. In our experience it is necessary to divide the population into two categories and consider each separately: (1) Those whose economic status is not above bare basic standards for existence, exclusive of illness. These people must remain the responsibility of the nation. (2) Those above the subsistence economic level, or the middle classes. These people want to and can pay the total cost of a basically necessary service. (3)

Dr. Hannah is Managing Director of Associated Medical Services.
From the ninth annual report of the Managing Director. Published in greater detail in the "Canadian Medical Association Journal" for June.

Those with a desire for and whose income will support a luxury service. This class should not be excluded from the privilege of providing against the cost of a basically necessary service in relation to the condition under treatment.

The first error committed in any approach we have so far seen in Canada lies in the tendency to regard such a division as discrimination and derogatory to everyone. All governmental studies have made this error. The net result is that all proposals base the amount of service required and the method of payment for that service on the level of the lowest income grouping. It does not necessarily follow that, because indigents and the low income groups must be sustained through taxation, this is the most economical or satisfactory method for all.

In our opinion the middle and upper class groups should be considered separately. The indigent and low income group have, in the past, been cared for largely by the medical profession. It has been generally admitted that such people have been better served than the middle classes who, unlike the upper income groups, cannot afford to purchase the essential but very costly methods of investigation and treatment.

It would therefore appear that the first concern should be to remove the burden of the indigent from the shoulders of the profession and spread it over the whole population through taxation. It is no less important that some method of relieving the middle class of the catastrophic costs of severe illness be evolved and of devising some means of making it possible for them to bear the costs of expensive investigation without threat to their economic solvency. Herein lies the second confusing element. It has been wrongly presumed that to accomplish this end we must provide an absolutely complete service without changing our present system of practice. This is neither necessary nor compatible with the application of the insurance principle to the cost of illness.

If we look back over the development of the application of the insurance principle, we will find that life insurance (which could be called death insurance) has been most successful. In it there is a bare minimum of human control possible. There is a maximum desire to prevent claims maturing. Consequently the administrators of such insurance funds find it comparatively easy to control abuses.

When we pass into the field of so-called health insurance, the situation is almost completely reversed as compared with life insurance. The broader the coverage in health insurance the greater the human control in maturing claims. Not only can an illness be the cause of maturing claims in health insurance, but the claimant can always use the cry of prevention to substantiate the necessity for improper claims. Unfortunately the claimant can, and frequently does, secure the support of those rendering the service and believe that when they have done so they have the support of the final authority.

If now we consider Government plans and add to the previously mentioned sources of pressure a third—the political—with all its implications, there is grave doubt in our minds that solvency will ever be possible under a service with complete coverage. However, the difficulties can be partly overcome in one of two ways.

The first solution lies in recognizing that a complete service for those from the middle class upward (income of $1,000 to $1,500 and up) is not necessary to answer the needs and demands of the public. In a province like Ontario where, before the war, there was one pleasure car for every four individuals, the cost of minor illness does not constitute a hazard to enconomic solvency. The first $25.00 of expense and the cost of the first two or three days of hospitalization in each fourteen-day period will constitute less of an economic hazard than the Christmas season or the advent of a wedding in the family circle. The institution of a plan to eliminate the major economic hazards of illness can be provided at less than half the cost of a complete coverage and will eliminate enough of the human controls to make it practicable.

The second method by which the problem can be solved can best be accomplished by the profession. If the profession will undertake to improve the efficiency of their methods of rendering service and place themselves on salaries ranging from $5,000 to $35,000 per year depending on qualifications and experience, which they themselves control, they can have security during active practice and for their old age. While practising they can have (in over 85 per cent of cases) from three to five nights a week free of professional interference. They can have a month's holiday each year with pay and without fear of losing their patients. In addition they can have from two weeks to a month each year (with pay) to do post-graduate study and every seventh year can be sabbatical. All this they can have and the cost of medical care can be reduced by from 30 to 40 per cent to the public.

These benefits can be had provided the profession is prepared to institute internal control and discipline. To date the profession has shown an extraordinary desire for control over health insurance. They have, however, avoided that internal control and discipline which the high calling and special privileges, which the profession enjoys, should demand. There is evidence that the profession as a whole has lost a considerable degree of respect of both the public and governing bodies. Unless the profession can rise to its full responsibility and exercise more disciplinary control over itself than has been manifest in the past fifteen to twenty years, not only will it lose the opportunity to advance the cause of medical practice through health insurance, but the profession is in grave danger of degeneration.

Doctor Hannah believes:

1. **A complete plan of health insurance is impracticable under present conditions.**
2. **Different classes require different coverage.**
3. **The medical profession must improve the efficiency of its methods of providing service.**

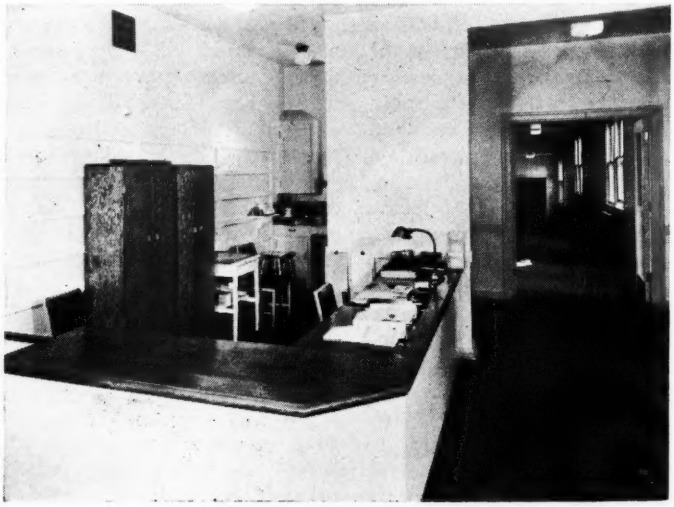
Low Cost Temporary Building for Tuberculosis in Vancouver

TO relieve the shortage of beds for tuberculosis patients in the Vancouver area, a temporary ward for from sixty-four to seventy patients was put up last year on the grounds of the Vancouver General Hospital and attached to the main tuberculosis building. It is operated as part of the Provincial Division of Tuberculosis Control.

Although erected primarily as a temporary building, it could be altered by some slight and not too costly additions into a permanent structure. The building is of frame construction without basement, 10 foot ceilings, tiled bathrooms and kitchen, battleship linoleum over the floors, gyproc lath and plaster in all rooms and a modern signal system and earphones at each bed. The necessary service rooms and diet kitchen are provided, but none of the usual operating rooms or other general service facilities are included. Heat is obtained from the central plant of the Vancouver General Hospital.

The cost of the building itself was $54,000 (1945). Equipment, which is the best obtainable and intended for later use in the permanent building, cost some $31,000, making a total of $85,000.

Writing of this unit, Dr. G. F. Amyot, Provincial Health Officer, states: "I believe that this type of building, if the structure is built for a one-storey purpose and considerable study put on the materials used, the size of foundations, etc., could form a model for cheaper hospital construction. I am truly alarmed at the apparent cost of building hospitals and the elaborate construction that is going into our modern



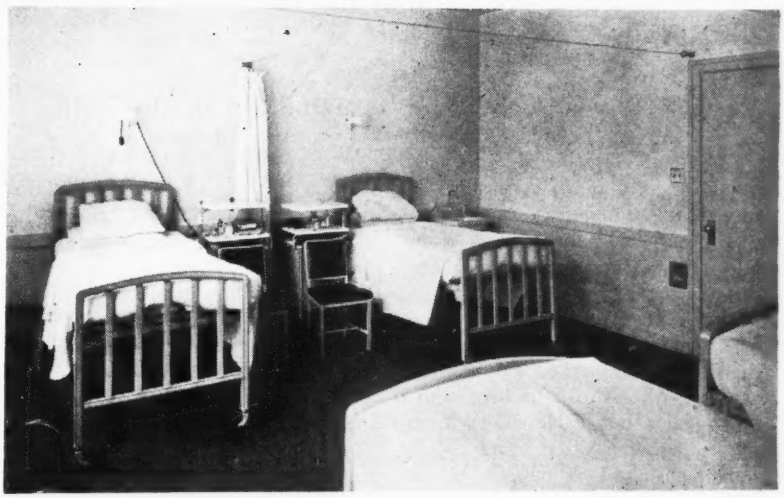
Enquiry desk and nurses' station.

Left—
Full use is made of the lawns and shade trees.

hospitals in small communities and places where there is lots of ground."

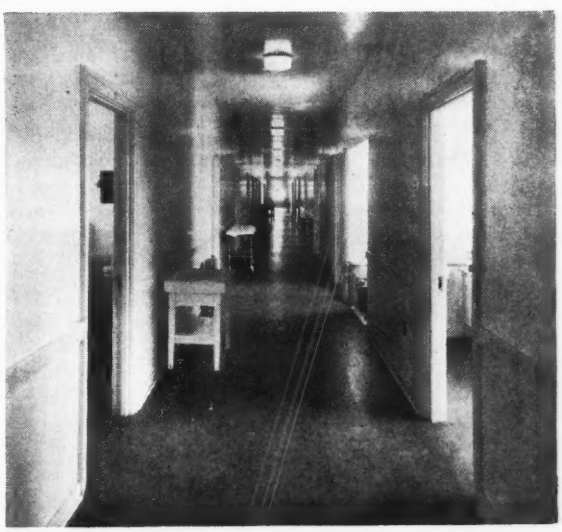
The provincial director of tuberculosis care, Dr. W. H. Hatfield, writes, "It is my confirmed opinion now, after utilizing a building of this type, that where land is readily available . . . . . the pavilion type of hospital (for tuberculosis) is by far the best, with all patients on one floor, all having good light and accessibility to the outdoors. All administration, etc., can be housed in a building quite separate and communicating with the various pavilions. I can see no increased problem in administration with this plan." As for the temporary building described here, Dr. Hatfield feels that it is working out quite satisfactorily but he would desire more access to the outdoors from each ward in a permanent building.

The Provincial Board of Health is now working on plans for a permanent tuberculosis hospital which will have a two-storey administration building and one-storey wards, in units of about eighty beds each. It is hoped that the increased roof cost and the spreading out of buildings can be compensated for by the elimination of elevators, the use of overhead instead of tunnel connections and by proper planning of the facilities for nursing care. Dr. Amyot refers to the desirability of having patients "where they can see the grounds and not feel that they are shut off for months at a time looking out into the open sky".



Above—
A four-bed ward.

Right—
A corridor.



Some revision of our basis of making grants to hospitals is overdue. We have a measure of uniformity in our grants, but we must recognize that there is far from uniformity in the *need.*

Hon. George S. Pearson, Provincial Secretary, B.C.

Colour Conditioning—

A new concept of colour, not as decoration, but as a medium which can be put to work.

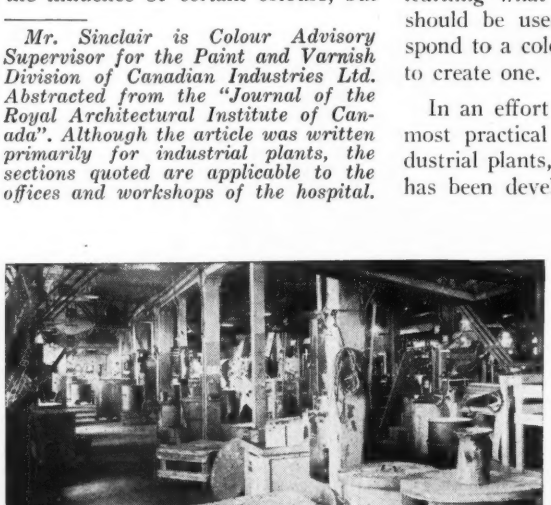
WILFRED D. SINCLAIR,
Toronto.

COLOUR is a positive force that affects the human nervous system. Every person with normal or near normal eyesight is aware of its stimulating influence on the senses. This would be a drab world if its colours were only sombre greys. Instead, each hue creates its separate individual impression, to the extent that even animals and insects have their own marked preferences and show this in their behaviour. Colour has a noticeable effect upon a person's disposition, and some people not only look happier under the influence of certain colours, but they feel better. An extreme instance of this effect would be found in the psychopathic and therapeutic treatment of nervous and brain disorders. Colour is a maker of moods, a shaper of character, and a creator of tastes and preferences; but its natural occurrence and lavish abundance encourage its being taken for granted like life, language, health and many other blessings freely enjoyed; and thus is overlooked the necessity of learning what colour is and how it should be used. It is easier to respond to a colour stimulus than it is to create one.

In an effort to make the best and most practical use of colour in industrial plants, "colour conditioning" has been developed as a design for maintenance, using a new concept of colour which subordinates the desire for decoration to the more practical purpose of putting colour to work so that it performs definite functions as does any other tool or mechanism.

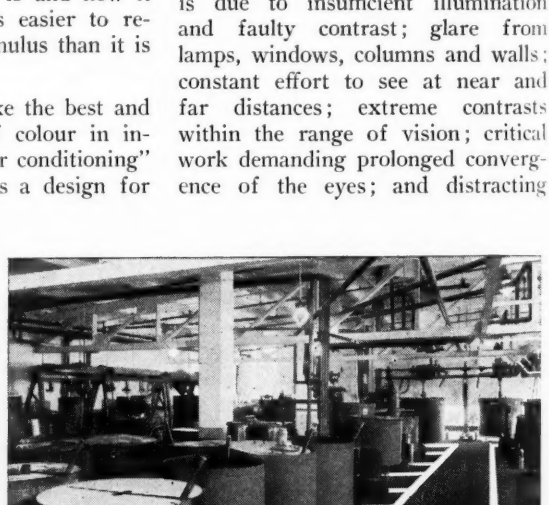
The whole concept of colour conditioning would be incomplete if it failed to take into consideration the established relationship between colour and light as partners in creating a seeing situation. The causes of eyestrain are numerous but the commonest ones and those most easily corrected are: poor visibility which is due to insufficient illumination and faulty contrast; glare from lamps, windows, columns and walls; constant effort to see at near and far distances; extreme contrasts within the range of vision; critical work demanding prolonged convergence of the eyes; and distracting

Mr. Sinclair is Colour Advisory Supervisor for the Paint and Varnish Division of Canadian Industries Ltd. Abstracted from the "Journal of the Royal Architectural Institute of Canada". Although the article was written primarily for industrial plants, the sections quoted are applicable to the offices and workshops of the hospital.



Confusion

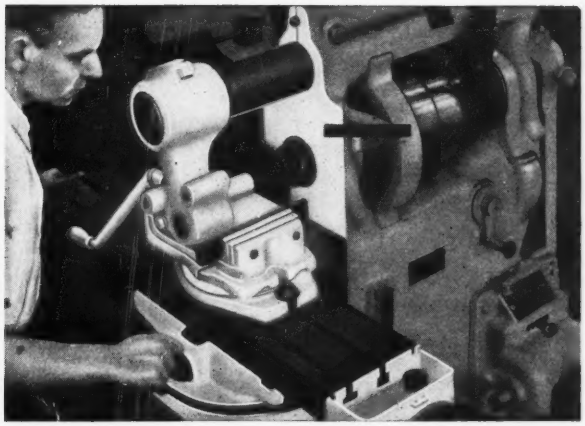
Aisles and storage spaces which are not properly designated and marked cause confusion and poor arrangement.



Good Housekeeping

White lines identify storage space and aisles. Orderliness and good housekeeping is a natural result.

BEFORE *being given a "Three-Dimensional Seeing" treatment, this machine was the same drab, dull colour as the material being worked. This "camouflage" delays production . . . . and results in mistakes and personal injuries.*



AFTER *the body of the machine is painted with Horizon Grey and the working surfaces with the contrasting hue, Spotlight Buff, the "camouflage" is removed and the material being fabricated, stands out in sharp contrast.*

factors such as moving parts, possibly only seen out of the corner of the eye, unshielded light sources and areas of brilliant, meaningless colour.

Light is essential to seeing and a lighting system should be installed only by competent engineers, because the object of a modern lighting system is to establish a brightness level which provides high visibility, ease of seeing and good seeing conditions. The engineer's task is made more difficult if he has faulty or unsatisfactory painting to contend with. Dark colours on ceilings, walls, floors and machinery swallow up his light and rob it of its effectiveness. They cause severe brightness contrasts that are hard on the eyes. Another unsatisfactory condition often encountered, and one that is equally bad, is that in which equipment finished in dark colours is placed against a bright wall. In looking from the dark equipment to the bright wall, the eyes and eye muscles are severely taxed.

Use of White

White has the maximum efficiency in the reflection of light, and it therefore gets the most out of existing illumination sources, but it is inclined to be too bright when used directly within the worker's view. Where the machine or the material being handled is fairly deep in colour (such as metal) white walls may be too sharp a contrast and may, over a period of time, make the worker's vision uncertain. White, therefore is most suitable and effective on ceilings, high bays and high wall areas, where it produces the maximum distribution of light from above and aids in the reduction of shadows. It minimizes the contrast between the lighting fixtures and their surroundings, hence reducing eyestrain, and it presents a clean, bright appearance. Colours on ceilings are to be avoided both to prevent visual distractions and to salvage all possible light from the fixtures, windows and other light sources. Besides those already mentioned there are some time-established uses of white that justify their continuance, such as equipment and rooms where spotlessness is essential: food machinery and equipment, medical examination rooms and dispensaries, kitchens and storage rooms. White is suitable in such instances because it makes dirt conspicuous and warns against negligence. For much the same reasons it is used on floors to whiten a corner and discourage littering, on floors near waste receptacles to invite neatness, and on baseboards to make sure the maintenance staff sweeps out all the dirt. It is used to mark traffic lines on floors to regulate traffic and stock piling. It is recommended for bins and shelving.

Colour should be used on walls, dadoes, floors and equipment to improve visibility by means of reflection and by supplying a suitable contrast background for the work being done. The choice of colour for contrast background is particularly important where employees are working, because it may be used to reduce any excessive difference between the machine and its background as well as that which might exist between the material and its background. Wall colours should be soft in tone to establish brightness ratios within the field of vision and yet durable enough to withstand soiling and abuse. Tones of yellow, ivory and peach are associated with sunlight and heat radiation, and they are ideal for use in rooms that are for the most part chilly, vaulty or deprived of natural sunlight. Green and blue, conversely, tend to lower the temperature psychologically, and they may be used to advantage in rooms regarded as psychologically warm. In general, the warm colours have a tendency to excite, whereas the cool colours—blue and green—are soothing. Large areas of any bright colour tend to irritate, and it is therefore wise to confine bright colours to small areas.

Offices

For almost every type of office, white is recommended for ceilings, because of its high light reflection and non-distracting qualities. Where ceilings are exceptionally high, it is desirable to carry the ceiling white down the side walls to a point about two feet above the door frame.

In selecting side wall colours for a series of offices, care should be taken that these are not brilliant, lively colours that emphasize contrast and cause eye fatigue. They should be light in tone and in a finish that diffuses light without glare or surface harshness.

(Continued on page 62)

Factors

in the care of

Orthopaedic Patients

J.-ED. SAMSON, M.D.

Chief, Department of Orthopaedics, Hôpital du Sacre Coeur, Montreal.

ORTHOPAEDIC surgery has developed so far during the last three decades that we may, without fear of exaggeration, classify it among the great specialties in surgery.

In order to understand its value one must take into account the incalculable number of dreadfully mutilated limbs which modern orthopaedic surgery has saved from amputation during the last two wars. It is not astonishing that young physicians, fascinated by the glare of its successes, endeavour with so much persistence to be admitted to the study of this science.

The procedure to be followed in the care of orthopaedic patients depends upon a variety of circumstances: the size of the city, the size of the hospital, the extent of the orthopaedic service, the competence of the staff, etc. My object will be to draw up an ideal plan for the care of cripples in a highly specialized centre.

A highly specialized centre in orthopaedics may be conceived in two different ways; it may be part of a large hospital, which gives it the advantage of help from other services, or it may operate alone with the assistance of a group of consulting physicians who ensure that it will maintain scientific standards of the highest rating.

In either case all patients are grouped in accordance with their age, their sex, their condition; all are treated by the staff under the supervision of a chief.

Being proud as a rule, the cripple feels very ill at ease when he is surrounded by those in good health who do not always understand his ways of seeing and doing things. When surrounded by cripples like himself, some of whom are more gravely afflicted than he is, the cripple feels more courageous and co-operates much more readily with hospital personnel.

It is advantageous to group orthopaedic patients by their category, as follows: bone tuberculosis with bone tuberculosis; spastics with spastics; fractures with fractures; polios with polios, etc. The reason for this is that these patients should not be subject to disappointment by the daily departure of patients suffering from dissimular illnesses which do not require as long a stay in hospital.

Plan Complete Treatment

The orthopaedic patient must often be confined a long time in the hospital preparatory to his surgical treatment and to complete this treatment by a closely supervised program of re-education.

We have at the hospital now a young girl, 21 years old, who has not walked since she was seized with poliomyelitis at the age of three. For six months uninterrupted treatment by means of plaster casts with traction was required to straighten her spine and her dreadfully deformed lower limbs.

She has just gone through the first of a series of surgical operations. Every three weeks she will be subjected to some operation, either to her feet, her knees, her hips and probably her spine, as planned in the program of treatment by the surgeon at the time of his first medical examination.

This means a stay of four or five months more in the hospital and as much time for the necessary re-education. You will be tempted to tell me that this is a special case and it may be so; but though it does necessitate the use of a hospital bed for 15 months, it is not exceptional.

The above is the type of case where one cannot hesitate because of the duration of the stay in hospital. The stake at issue is a worthy one and success depends chiefly upon a full realization of the whole plan of treatment. How many times are we forced to send a patient home ahead of time on account of a lack of beds or for financial reasons!

Adequate Facilities Needed

The orthopaedic hospital should be provided with all the facilities necessary for the completion of the treatment. If required, it should be possible to provide the patient with a special shoe as well as with orthopaedic appliances.

The orthopaedic hospital should have:

(a) A large gymnasium with swimming pool where, under the supervision of competent physical therapists the patients can co-operate actively in hastening their physical and psychological recovery.

(b) Shoe shop, work shop, smith's shop, carpenter's shop, etc.

(c) Occupational therapy, including embroidery, knitting and handicraft rooms for women.

(d) Class rooms for the children

An address given at the American College of Surgeons Regional Meeting, Montreal, March, 1946.

where they can follow the regular school curriculum.

(e) Recreation rooms for all where periodicals and books would be supplied, where moving pictures could be shown and where singing would be encouraged—the whole to be undertaken with heartiness, cheerfulness and happiness.

It is indeed astonishing and comforting to see how well the crippled patients enjoy themselves together. With us they always have a fiddler willing to entertain and amuse them. Most of them leave the hospital with regret. In addition to their physical restoration, they have found among the hospital personnel a warm sympathy of which they will always have fond memories. The hospital has become to them a second home to which they like to pay return visits to comfort and cheer their former companions.

Their happiness will be increased by the fact that during and after their convalescence they may have had the opportunity of learning a trade in accordance with their aptitude, a trade which will help them gain an honourable livelihood and play an active role in society, in other words to be "somebody".

C.N.A.-C.H.C. Committee

Discusses Nursing Situation

The Joint Committee appointed to study and make recommendations respecting the present nursing situation met in Montreal on June 22nd. The Canadian Nurses' Association was represented by Miss F. Munroe, Rev. Mother Audet, Miss K. Connor and Miss S. M. Hall; the Canadian Hospital Council was represented by Arthur J. Swanson, Dr. W. D. Piercey and Miss Jean Masten. Mr. Alex. Esson and Dr. Agnew were unable to be present.

After a discussion of various aspects of the present critical shortage, several steps were proposed:

1. In view of the present publicity on the subject, much of which is based upon obsolete information or is quite inaccurate and unfair, the provincial registered nurses associations and provincial hospital associations are asked to provide and sponsor adequate and factual joint publicity—paid and editorial—indicating the acute shortage of personnel of all kinds facing all hospitals. Such publicity should review the reasons for this situation and the problems facing the hospitals, give statistical data concerning nurses available, types of positions available, present source of supply, cost of training nurses, etc.

2. In those provinces which have not already done so, the provincial registered nurses association, the provincial hospital association and the provincial government might jointly set up a course of training covering a period of nine to twelve months for the preparation of nurses' aides.

3. Joint provincial committees of the two associations should be set up to consider the matter of requesting provincial governments to subsidize accredited schools of nursing.

4. The special problems created by the staffing of D.V.A. hospitals might be discussed with that Department.

In a press release issued at the time it was emphasized that "The public should be made aware of the facts, *as they are,* regarding hospital personnel, rather than quoting or giving publicity to reports that are obsolete and to conditions which have long since been corrected". As for the preparation of nurses' aides, "Present courses set up for rehabilitation schemes were studied and it was felt that these courses were good and should be extended to non-service personnel, so that a sufficient number of nurses' aides may be made available with the least possible delay. It was the opinion of this Committee that this could only be done by provincial government subsidy."

It was emphasized that the present system whereby nurses for all fields of service are trained in 169 civilian hospitals operating schools of nursing, and graduating approximately 3,500 nurses annually, does not and cannot continue to prepare nurses in the numbers required and for the variety of fields of service in which they are employed.

It was agreed that too much emphasis cannot be placed upon the fact that hospitals are bearing all the cost of conducting schools of nursing to provide nurses for the following fields of service; hospital; general staff; head nurses; supervisors; instructors; administrators of hospitals; public health and visiting nurses; industrial; T.C.A. and other air lines; doctors' and dentists' offices; private duty nurses. None of the employers of these nurses, other than hospitals, give any financial support to the preparation of the nurses they are employing in increasing numbers.

Dr. G. Brock Chisholm Assumes World Post

Dr. G. Brock Chisholm, deputy minister (health) of the Department of National Health and Welfare, has resigned his position to become executive secretary of the interim commission of the international health conference of the economic and social council of the United Nations.

Dr. G. D. W. Cameron, director of health services in the Department, has been named to succeed Dr. Chisholm.

Important

Owing to the demand for hotel accommodation in convention cities throughout Canada, and the United States, all who are planning to attend the hospital conventions this fall in Vancouver, Calgary, Saskatoon, Winnipeg, Toronto or in Philadelphia are urged to make their hotel reservations without delay. This applies to trustees, administrators and managers, nurses, women's aid members, physicians, medical record librarians, dietitians, technicians and all others planning to attend these meetings.

* * *

In the case of Women's Hospital Aids Association of Ontario, the names of those wishing to attend, and the number of persons to a room, should be sent to the President, Box 322, Bayfield (Huron County), Ontario, not to the hotel.

Basic Considerations in
Personnel Administration

By O. A. PETERSON,
Personnel Manager,
B.C. Electric Company

IN the period preceding the Industrial Revolution, major changes in the workers' environment were those involved in the shift from serfdom to the emergence of guild organizations. In the early part of the period the most common type of employee-employer relationship was that in which employers were masters and the employees were, in effect, slaves. This relationship most commonly began in military conquest, from which the master-slave relationship naturally followed. The slave thus acquired was a chattel, the personal property of his master, and the relationship involved all the wide range of attitudes from kindness to consummate cruelty and from hatred to service affection. The services performed by slaves were similarly varied, ranging from menial tasks of all sorts to specialized responsibilities in agriculture and military service.

From this specialization of function the status of the free artisan developed. The group of free artisans was a distinct minority. The first craftsmen were predominantly either serfs or slaves. Some artisans then became independent and became wage workers, but this status differed essentially from that of the modern workers, for they were not free to charge any wage they might wish. Wages were not, in other words, either strictly competitive or fairly set by the worker or his customer; rather, wages were determined by the all-powerful church authorities of the period.

The Industrial Revolution

Then came the industrial revolution and we are all familiar with the effect on the worker of that time.

Then we began to see the new form of industrial organization in which companies were formed, with shareholders, directors, management, etc. Then came the huge plants in the U.S.A., providing mass production and line assembly methods. Bigger and bigger companies were formed.

What can we draw from these pictures? In the days of serfs and slaves we see that the worker accepted his lot with very little grumbling. He knew his master well and his master knew him. But as we move on through the Industrial Revolution and the U.S.A. production plan, we see that the worker became more and more remote from his master or masters; in fact he became, as is often said, just a small cog in the machinery. He became more and more disgruntled with his lot in life. In most cases he had lost the pride of work because of the line assembly method. His sole object each day was that of security.

Something Missing

Do we now see that some part of management was missing, namely, the contact between the worker and management? It has always surprised me that management failed to see this necessity much sooner; in fact, many companies have not realized it yet. It is odd that management would make sure that they have an accountant, a purchasing agent and an engineer, and yet fail to have some person appointed to look after the human element. After all, what use are material things without the human element to create and appreciate them?

In the past twenty-five years or so many companies have realized that this is the missing link in their management and have created a special department to carry out the function of personnel administration.

What are the responsibilities of such a department? It should see that employees have been properly selected, placed and trained for the position they are to fill; to see that employees have their abilities recognized so as to move forward in the company; to see that they are fairly rewarded for their contribution; to make sure that they receive additional security by a sound health and safety program.

Let us discuss these points in more detail. The old method of just interviewing a person whom you wish to hire is not good enough. You owe it to the new employee and the company to make sure that he is the right person for the job. Preliminary interviews are given to eliminate the obvious undesirables. Then those who are accepted for consideration should be given a further screening by means of tests. These tests bring out the aptitude, interests and personality traits. A "profile" of the individual is obtained and this is compared with the profile of the job. Thus you come to fitting the right person to the right job.

When you have found the right person for the job, it is only fair that he should be properly inducted into the company and the job; so he goes to the training department and learns something about the company, its organization and his job.

The new employee is entitled to know exactly what his duties and responsibilities are to be on the job, and so an up-to-date company has complete job descriptions and is able to inform the new employee. Furthermore, the new employee should be able to know what the minimum and maximum rate of pay is for the job and what the policy of advancement is.

He should be told all about other benefits, such as insurance and medical plans, vacation and pension plans, and all other plans which add to his security. It is not good enough to place him on the job and pay no further attention to him. He should be "rated" on his job at least once a year and should be informed as to how he is coming along.

The day is here when employers must pay attention to the individual employee and any company which fails to do this is headed for "plenty of headaches".

From an address given at the 1945 Pre-Convention Hospital Administration Course at Vancouver.

The Capping Ceremony

Above—Miss Blanche McPhedran, in the absence of the Principal, Miss Myrtle Graham, presents the "Charge to Student Nurses". At her left are Cannon J. E. Ward and Miss Mary Oliver.

AFTER five months of preliminary training, student nurses who have proven themselves qualified, both academically and in their practical work, to continue in the profession are formally accepted into the school of nursing and cease to be probationers. At this time the girls receive their bibs and caps and in a great many hospitals it has become customary to hold a "capping ceremony". This ceremony marks a definite step forward. It encourages the students and impresses upon them the importance of the career chosen.

A good example of this significant service was that held in July at the Toronto Western Hospital. Twenty-two students, each accompanied by a "big sister", marched into the reception room of the nurses' residence and formed ranks around three sides of the long refectory table. After "O Canada", the beautifully worded "Charge to Student Nurses", written by Mrs. Margaret Rhynas, was read to the class by Miss Blanche McPhedran, Assistant Principal.

The girls were then called forward in groups of four or five and had crisp white caps pinned on by their "big sisters".

The "Candle Lighting" was a unique feature of this ceremony. Lighted by the President of the Student Council (Miss Shields) the candle was presented to the President of the Preliminary Class (Miss Milne) with the words:

"In lighting this candle for the Class of 1949, we wish to brighten for you the path laden with ideals for the nursing profession. The light symbolizes knowledge. The white caps you have received symbolize the spirit of unselfishness, sympathetic understanding, and devotion to duty which form the foundation of our school, and which you are pledging yourselves to carry on."

In accepting the lighted candle the President of the Preliminary Class replied:

"The Class of 1949 accepts the responsibility and privileges you have given us. We hope to work so that your light will shine in us and make us truly worthy of those who have gone before."

There followed a short address by the hospital administrator, a well-selected solo and a dedication prayer. With the singing of the national anthem, the newly capped students filed from the room and later had tea with the guests.

Jessie Fraser.

The President of the Student Council lights a candle for the Class of 1949.

Changes Inevitable *in Nursing System*

R. A. SEYMOUR, M.D.
Assistant Superintendent,
Vancouver General Hospital

IT is interesting and profitable to speculate on the changing demands for nursing service. Looking back many years these changes have been gradual but none the less evident. The demands for changes have arisen from the public, from the medical profession and, much to their credit, from the nurses themselves.

In early years most hospitals were staffed with student nurses and the wards and the students were supervised by graduates. Much of the routine labor of housekeeping and dusting and cleaning, etc., was done by the students, but as advances in nursing techniques, developed and responsibilities were added, more and more time of the student nurses was taken up with lectures, classes and demonstrations. As a result, lay help began to be employed for duties that did not entail actual nursing. Instead of a day's work on the wards for practical experience and evening hours for lectures and studies, the curriculum was changed. Classes and lectures were given during the day and this necessitated the employing of lay help. Further, these adjustments in curriculum and the cutting down of hours available for ward work and the demands for experienced nursing resulted in the employment of graduates for general duty on the wards in increasing numbers. With increased knowledge they were able, and were required, to use and interpret, more and more, the techniques that were developed in the practice of medicine.

Other special aids were developed and employed and personnel trained for this work such as in the fields of medical technology, dietetics and radiology. Graduate nurses were given further training in specialities for duties in certain departments such as the operating theatre, case rooms, etc. As these postgraduate courses became more essential and the demands of medicine became more critical, the standards of basic training were raised. It was not long before the universities were called upon to help in this advanced training and today we see nurses graduating with degrees of B.A. and B.Sc.

All this is costly and takes the nursing profession further away from actual bedside nursing. The change in the immediate future therefore must be the stressing of development of personnel for bedside nursing, the hour-to-hour and day-to-day care of sick and convalescent patients.

Points of View

When we study the economic situation we can see at once why a change is necessary and where the change will come. Let us look at it from the nurse's point of view. She is a highly qualified person with powers of understanding and observation, a knowledge of basic sciences, and training in special techniques. The educational requirements call for junior matriculation, and then three years' specialized training without remuneration. Further training may require, in addition, one or two years in university or postgraduate work in hospital, again without remuneration. That is, three to five years more education than the average individual who enters commercial life without special training. The nurse thinks therefore, when she enters the labour market to sell her abilities, that she receives inadequate compensation in comparison with other workmen less well trained. She thinks that many of the duties assigned to her profession can be done by persons less highly trained, that much of her training and knowledge is wasted. *The solution of these dissatisfactions would appear to be higher wages for the well-trained nurse, and the employment of less highly trained personnel for the less important duties.*

It seems inevitable that a change in nursing service must come. It is wise to recognize this and be prepared for it.

Now let us look at the problem from the hospital point of view. Hospital authorities do not wish to see talent wasted, nor can they afford with the present hospital income, to pay high salaries to competent nurses for work that less highly trained personnel can do well at a lower wage scale. If circumstances compel them to do this, then their only recourse is to increase hospital rates to cover this cost, or else pass it on to taxpayers or endowment reserves, by way of their deficit. Just criticism will then develop and force a more economic labour set-up.

What do the patients think of this situation? Hospital rates which include nursing service have been steadily rising and the average patient cannot afford the costs of sickness and all it entails. Indigents and charity patients, most of whom would like to pay their share, cannot do so. The well-to-do are ever mindful of costs and value received, in spite of their easy ability to pay. But the large middle group feel this burden of increasing hospital costs the most, and being conscientious are more and more protecting themselves by various insurance schemes. The premium rates, of course, are based on costs. Should the Federal health insurance scheme develop it will not take long for nation-wide cost comparisons to show up the fallacy of employing highly trained personnel to do medium grade work.

Changes Inevitable

It seems inevitable therefore that a change in the nursing service, which has already started because of labour shortage, will have to come.

From an article in the Vancouver Medical Bulletin.

It is wise to recognize this, plan for it and be prepared for it. The question therefore arises, how can a complete nursing service in the broad sense be set up, having in mind the costs as affecting patients and hospitals, and at the same time keeping control of the necessary nursing standards required?

To answer this question by an example, the nursing service to the patient in a broad sense could be divided into three types or groups that would supply the needs in hospitals and in homes.

1. Specialized Group

The first group in this suggestion would be a specialized group and includes supervisors, instructors, operating and case room assistants and public health nurses. It is obvious that this group should require higher training in university or post-graduate work in hospitals.

2. General Duty Group

The second group, now spoken of as the general duty nurse, would be composed of those who had graduated from qualified nursing schools but without further post-graduate qualifications. They would give actual bedside nursing care to moderately or seriously ill patients in hospital or in homes. It should be pointed out here that the training period of this group could be reduced from three years to two years, as exemplified in the accelerated course developed during the war years in the Vancouver General Hospital. This wartime course concentrated all the lectures and classes to almost a two-year period, leaving the final eight months for uninterrupted bedside nursing duties. The third year could be an apprenticeship before the diploma is given or the Registered Nurses' examinations are written, insuring adequate experience. Some modification of the Registered Nurses' Act and some detail changes in the course would be necessary. This group could proceed, if they desire, to university or post-graduate work to qualify for certification in the first group.

3. Nurse Aides

The third group could be composed of personnel with Grade XI standing who have qualified after a two months' training course, including the requirements of first aid certificates and home nursing certificates, and practical demonstrations of some hospital procedures. This group would care for convalescent or less sick patients. It does not require three years of special training to give bed baths, take temperatures and perform other simple nursing duties. Many very sick patients are taken care of at home by relatives with little or no training. Such a group, called nurse aides or hospital attendants could be quickly taught and brought immediately into use. Male attendants also could be similarly trained for male wards.

The great need for this third group is exemplified and proven. As above stated the high cost of care of patients in hospital is still climbing and sick patients, already burdened, cannot afford it. The shortage of available nurses is very apparent and this plan would alleviate this situation quickly. Existing nursing schools cannot train any more nurses than they were doing without lowering their standards. The loss in nursing personnel in hospitals is continuous and it has been estimated that the average student nurse stays in hospital to nurse for only two years after graduation. Although their education and training remains of value for future necessity it is soon lost to the community for immediate hospital needs. Now the third group of personnel, aides or attendants, could be replaced more quickly and the male attendants might continue on until superannuation.

All over Canada there is a desperate need for increased hospital accommodation. Hundreds of patients would come into hospital tomorrow if there were hospital facilities. Even if more hospitals could be built there is not the nursing personnel to staff them. Even if army hutments were to be used temporarily there is not the staff for them. Since it is impossible to increase our supply of trained nurses in our hospitals sufficiently, it seems obvious that quickly trained lay help would solve this most pressing problem rapidly, efficiently and economically.

Survey X-ray Equipment in Saskatchewan

A survey and inventory of all x-ray facilities in Saskatchewan hospitals is being conducted by the Health Services Planning Commission in preparation for the inauguration of the provincial hospitalization scheme and to make sure there are adequate x-ray facilities to meet the needs of various communities.

The survey is being conducted by Dr. L. K. Poyntz, M.D., L.L.B., of Victoria, who was recently appointed radiologist for the Swift Current Health Region.

A member of our editorial staff enjoys beautiful scenery in Quebec, near Baie St. Paul

Photograph courtesy Catherine Cartwright,

Environmental Sanitation
. . as Applied to Hospitals

Part II—Food Handling and Dishwashing

R. BOWERING, B.Sc., (C.E.), M.A.Sc.,

Public Health Engineer, British Columbia Board of Health

PROBABLY the most important place in the hospital, as far as environmental sanitation is concerned, is the *kitchen*. From the kitchen food goes to every patient and staff member, and back to the kitchen come their dishes. Where improper technique is used in the kitchen, it may readily be seen how cross-infections could occur in handling food. Food handling involves three factors: the place in which food is handled or prepared; the utensils and dishes; and the personnel.

Kitchen Environment

The floors of the kitchen or other food-handling room should be properly constructed and should have an impervious surface. This type of floor is easily cleaned and thus is more likely to be kept clean.

The walls and ceilings should be painted a light colour. The walls should be washable. The days of painting a kitchen wall with a dark paint, "to hide the dirt" are past.

Proper light and ventilation in the kitchen discourage flies and encourage cleanliness. Artificial lighting should be provided so that a minimum of ten foot-candles of light is available for all working surfaces.

The toilet facilities for kitchen personnel should be well lighted, painted a bright colour, and maintained in a clean condition. Hand washing sinks should be provided with hot and cold water, individual soap and towels, so that each person may wash his hands before commencing work or after going to the toilet. Signs should be posted in all toilet rooms reminding employees to wash their hands before returning to work.

Utensils

The utensils and equipment used for the preparation of food, and the dishes should be constructed in a manner that promotes easy cleaning.

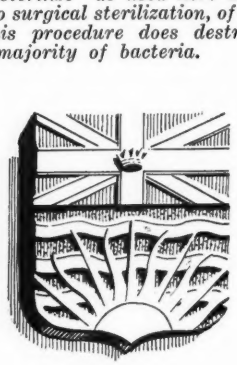
All equipment, such as meat blocks, refrigerators, store rooms and shelves, should be kept free of encrusted materials, and should be washed frequently. Insects should be controlled and all cooking utensils should, after washing, be given some bactericidal treatment.

Dishwashing

In all dishwashing techniques there are at least three steps: first, the scraping of the dishes to remove food particles; second, the washing of the dishes in a good cleaning solution; and, third, the "sterilizing" of the dishes, using either heat or a chemical.*

If a dishwashing machine is used, all dishes should be thoroughly scraped before being placed in it. The washing water in the first compartment of the dishwasher should be kept at a temperature of about 140° Fahrenheit, and the supply of detergent should be kept up to strength. In the second compartment the dishes should be subjected to a rinse spray which has a temperature of at least 170° Fahrenheit.

** To "sterilize" as used here does not refer to surgical sterilization, of course, but this procedure does destroy the great majority of bacteria.*



Where dishes are washed by hand, there should be at least a two-tray, and preferably a three-tray sink. The technique is first to scrape the dishes, removing all food particules, and then to wash them in the first compartment of the sink, using water of from 110 to 120° Fahrenheit and a cleansing agent. The dishes should be washed until visibly clean. They should then be placed in wire baskets in the second compartment, and totally immersed in water having a temperature of at least 170° Fahrenheit, for two minutes. An alternative method is to immerse the cleansed dishes in water at 110°, to which has been added a chemical compound. Of these the most common are chloride compounds. Directions for use accompany most containers and, if followed carefully, generally produce satisfactory results. Several new chemicals are now on the market for sterilizing dishes, and information as to the value of these may be obtained by writing to your provincial health department.

After washing and sterilizing, dishes should be allowed to air dry. *Dish towels should not be used.*

In short, there are five important factors in dishwashing:

1. A simple knowledge of washing and cleansing fundamentals on the part of the employee.

2. An efficient dishwashing machine, or efficient equipment for hand-washing, if no machine is available.

3. If the water is hard, a good water-softening agent.

4. A washing method which permits work to be done at the peak of efficiency.

5. Personnel trained to use available equipment to the best advantage.

There are some very good single service containers now on the market, and many hospitals will find these economical because of the sav-

ing of time required for washing and sterilizing dishes.

Storage

Utensils and containers should be stored at least 18 inches above the floor. Cups and glasses should be stored upside down in cupboards. Plates and other dishes should be stored in dust and vermin-free cupboards, which should be provided with glass doors to encourage cleanliness and tidiness, and to discourage insects. Knives, forks and spoons should be so stored in drawers that they may be picked up by the handles.

Refrigeration

It is a good rule with prepared foods to cool all foods which cannot be kept hot. Good refrigeration will prevent the deterioration of food and the growth of organisms harmful to health. All perishable foods should be kept at a temperature below 50 degrees Fahrenheit.

Milk

Milk should be obtained from an approved source and pasteurized. If pasteurized milk is not obtainable, it may be pasteurized in the hospital. Two vessels are needed, one of which should be small enough to fit loosely inside the other. The milk is put in the inner vessel and enough water in the outer one so that the level is higher than that of the milk. The equipment is placed on the stove and heated until the temperature of the milk reaches 161° Fahrenheit. It is necessary to stir the milk occasionally during this period. It should then be cooled as rapidly as possible to 50° Fahrenheit or lower.

Kitchen Personnel

All personnel in the kitchen should know the means by which communicable diseases may be transmitted through dishes and food. With this knowledge, the need for proper techniques in the handling of dishes and food will be self-evident. Personnel should be very careful about personal hygiene for aesthetic as well as health reasons. Proper attire should be provided for kitchen employees: a washable dress or apron, to be used only when preparing or serving food. The use of a cap or hair band should be encouraged. All persons on duty should be free of colds, communicable diseases and skin infections.

Metropolitan Hospital Finds Helpers

Miss Valerie Drope, superintendent of nurses at the Metropolitan General Hospital in Windsor, is seen above talking with some of the 70 applicants who appeared in response to an advertisement for hospital helpers. From the group will be selected 12 to participate in the first training class. An intensive one-week instructional course will be followed by two to three weeks of floor instruction with each student assigned to a trained nurse. Those who qualify will be known as "helpers" and if the project proves successful a second class may be undertaken.

Photograph Courtesy, The Windsor Star.

The technique of serving food is also important. There should be a minimum handling of food between preparation and serving. Cups and glasses should never be picked up by placing the fingers inside. Knives and forks should always be held by the handles.

A lecture course for restaurant employees is in the course of preparation by the provincial Board of Health. Copies of this course may be obtained by writing to the Board.

Dr. G. F. Strong Heads C.M.A. Committee on Economics

Dr. G. F. Strong of Vancouver was named chairman of the Committee on Economics of the Canadian Medical Association at the annual meeting in Banff. He succeeds Dr. J. H. McPhedran of Toronto who has been chairman of the Committee for several years. Dr. Strong has long been a student of medical economics, taking an active part in health insurance and other studies and also participating in the work of the C.M.A. Committee as chairman of the British Columbia Division. Dr. A. E. Archer of Lamont, who was president of the Association at the time that basic principles were being laid down by the committees at Ottawa, continues as consultant on economics.

Dr. R. I. Harris Elected

Dr. R. I. Harris was named president-elect of the American Orthopedic association at their recent meeting in Hot Springs, Virginia. This is the highest honor in the gift of orthopedic surgeons and a special tribute to Canadian surgery. Dr. Harris is a senior surgeon at the Toronto General, in charge of orthopedics, and an assistant professor of surgery in the University.

Obiter Dicta

How Safe is a Fire-Proof Building?

THE satisfaction and complacency felt by most of us with a "fire-proof" building must have been rudely chocked by the catastrophic fire at the LaSalle Hotel in Chicago, a fire in a modern "fire-proof" building that cost 60 lives and injured scores of others. It is of especial concern that one well known hospital official lost his life and two administrators were injured. Although this 21-storey, 1000-room hotel was built of cement, stone, steel and brick, the inflammable material in the rooms involved was sufficient to set up a veritable inferno of fire. The lobby alone with its wooden panelling is said to have contributed to the majority of the deaths. Dr. Robt. F. Brown, medical director of St. Luke's Hospital, writing in *Hospitals*, states, "Hospital officials can not be smug even if their buildings are fire-resistant or fire-proof. Many things may burn inside the building, such as furniture, draperies, gas and liquid chemicals and a hundred others."

It would appear that many of the deaths were caused by the volumes of hot air and toxic smoke that raced up the open stairways and elevator shafts. Editorially the same journal notes, "The greatest dangers in a fire-proof building are smoke and hot air, open stairways, unseparated elevator shafts, improper storage of material, obsolete fire-fighting equipment, delay in reporting the fire." Dr. Brown, himself an eyewitness, emphasizes that the fire department should be notified at once *before* summoning employees to fight the fire; that all hospitals should have regular fire drills; and that all employees should be thoroughly instructed respecting the location and use of extinguishers and fire hoses, the danger points, the importance of closing doors and windows, etc. Fire hose and other equipment should be examined regularly. Are outside fire escapes adequate and in good repair? In these days of synthetic materials with combustion products of unknown toxicity, of increasing cigarette fire hazards, and of personnel shortage with patient overload, increased vigilance must be maintained if similar catastrophes are to be avoided.

Formula for Bed Requirements

A NEW formula for estimating the needs for general hospital beds has been proposed by the Commission on Hospital Care now surveying hospital needs of the United States. This is based upon the assumption that the number of beds required is directly proportional to the hospitalized portion of the *crude* birth and death rates (i.e., the total numbers of births and deaths, multiplied by 1,000 and divided by the total population). For the obstetrical service this is calculated at about four beds for each hundred births, based upon an average stay (in normal times) of eleven days and some 75 per cent occupancy. It is presumed by the writer that only births likely to occur in hospital are considered, a factor that may be much affected by the present legislative trend.

As for general beds, statistics indicate that the public uses about 250 days of general hospital care for each death and correlated sickness in a general hospital. Expressed in terms of average daily census, the *bed-death ratio* is 250 divided by 365, or about .7. For each hospital death seven-tenths of a bed is used for one year. This figure was found to be sufficiently constant in the different states to warrant its use as a basic figure. However, variations do occur especially between individual hospitals. The ratio quoted corresponds to an average stay of 10 days and a hospital death rate of 4 per cent. Moreover, the community death rate must be modified

to the figure indicating the number of deaths expected to occur *in hospital*. In 1936, 29.5 per cent of deaths in the U.S.A. occurred in hospital; by 1944 the percentage had risen to 38.3; now in many states it is 50 per cent or higher. The Commission, noting that the death rate in the United States is about 10.6 (or about 5.3 in hospitals—50 per cent) calculates that the number of occupied general hospital beds needed is .7 (bed-death ratio) times 5.3, or 3.71 occupied beds; allowing for 75 per cent normal average occupancy, the national need is 4.95, or *5 beds per thousand of population*. This would mean a 40 per cent overall increase in general and allied special hospital beds.

This formula seems worthy of further thought. Certainly it is better than the old so-many-beds-per thousand formula, which this office has found to be a very unreliable guide. We are pleased to note that the Commission does not advocate this as a complete and reliable guide, but stresses the importance of considering many local factors, just as in the case of the old formula. Especially in the case of small hospitals in communities closely adjacent to large cities with well staffed and equipped hospitals should extreme care be taken in accepting any formula figures without modification. Changing treatments may affect estimates of beds required; for example, penicillin and the sulphur group have not only reduced the mortality of pneumonia and other infections but have shortened considerably the stay of osteomyelitis, empyema, mastoid and other hitherto long-stay patients. In other words, work out your formula requirements; then revise it, up or down, in the light of a number of local factors and the anticipated legislative, economic or other conditions or developments.

Serious Breach of Faith

A SPECIAL concession given to hospitals across Canada is being jeoparadized by the actions of certain small institutions. In April, 1942, following a decision of the Dairy Products Board to reduce the quota of ice cream to dealers and thus to consumers, representation was made to the Board by the Canadian Hospital Council pointing out the special value of ice cream as a food for patients and requesting that the public hospitals be permitted to purchase the quantities deemed necessary for their patients. The Dairy Products Board kindly arranged that no restriction should be placed on the volume of ice cream which might be made by hospitals for their own use and, likewise, ice cream made for hospitals by dairy plants producing ice cream was exempt from restriction.

We are now informed by the chairman of the Board that certain hospitals, apparently small ones, have entered into arrangements with local restaurants whereby shipments of ice cream to these hospitals have been diverted to the restaurants. It would appear that very little of this ice cream has been served to patients and the restaurants have thus been able to secure quantities in excess of their quotas for sale to other customers. The Board has notified us that the situation is being investigated and if it is found that other hospitals are abusing this privilege, it will be necessary for the Board to take action without delay. This may include cancellation of the exemption to hospitals.

It is hard to believe that any of our hospital officials would permit such abuse of a much-appreciated privilege to take place. Food products that are in short supply must, of necessity, be placed on a quota basis. To circumvent both the spirit and the letter of the law by such action is not only an inexcusable disregard of the rights of others but jeopardizes seriously the esteem and respect in which the hospitals as a whole are held by those upon whom has been placed the responsibility of devising regulations to make our limited supplies of food, clothing and materials be of most service to the most people. Our hospitals have received many concessions at Ottawa and in provincial legislation because of their obviously altruistic regard for the sick and their sincerity in the interpretation of exemptions or privileges extended. Every hospital official has a definite obligation to preserve this priceless reputation of honest dealing.

Canada Lacking in Visual Education

THE March issue of the *Journal of the Association of American Medical Colleges* contains a series of articles on the use of visual technics in medical education. This symposium of addresses given at the last annual meeting of the Association indicates the great forward strides taken on this continent to develop this most effective method of teaching. The article in the May issue of *The Canadian Hospital* by Miss Maria Wishart well illustrates how effective has become that particular aspect of visual education. The use of films or slides in colour or black-and-white and the use of the reflectoscope, not to mention demonstrations, have added greatly to the effectiveness of classroom instruction.

The good name of our Canadian medical schools was not particularly enhanced by the details of one report submitted. A survey of teaching methods has been made by the Conference of Professors of Public Health. In response to the question, "Have you made use of motion pictures on public health and related subjects?", 46 American schools replied "yes" and 13 "no"—about 3½ to 1. As for the Canadian schools, four said "yes" and four "no"—only half. American schools reported 56 different titles and Canada but nine; perhaps the greater number of American schools might be a factor here.

In reply to "How many titles were used in the course of one year?", one Canadian school reported one title, another six to ten titles and a third eleven to fifteen. This was broadly comparable to the experience of American schools, but there two schools reported sixteen to twenty-five titles and two used thirty-six to fifty. In extenuation it might be noted that a number of the films used came from the U.S. Public Health Service. Also all four Canadian schools now using films stated that they would increase their use. There would seem to be a real opportunity for governments, universities and, possibly, supply and drug houses to finance more of these productions.

Standing, left to right: Dr. J. A. Clark, new president of the Maritime Hospital Association; Dr. George Stephens, superintendent of the Royal Victoria Hospital, Montreal; Mr. Richard Jones, public relations director of the Blue Cross Commission, Chicago; Mr. E. D. Millican, executive director of the Quebec Blue Cross Plan; Mr. A. J. Swanson, president of the Canadian Hospital Council and Dr. W. P. Morrill, research director, American Hospital Association.

Seated, left to right: Miss Ruth Wilson, executive director of the Maritime Blue Cross Plan; Mrs. H. W. Porter, secretary of the Maritime Hospital Association; Dr. R. J. Collins, retiring president of the Association; Rev. Mother M. Ignatius, chairman of the Nova Scotia Section; Dr. J. A. McMillan, chairman of the Maritime Blue Cross Plan.

Lively Discussions Feature
Maritime Hospital Convention

THE fourth annual meeting of the Maritime Hospital Association was held at the Digby Pines Hotel on June 25, 26, 27, concurrently with conventions of the Maritime Blue Cross Plan, the Maritime Hospital Aids Association and the Hospital Exhibitors Association. The program centered around a discussion of hospital problems in the three member provinces and the active interest of hospital people in these common problems was attested by the attendance of approximately 375 delegates. Many out-standing authorities on various phases of hospital work from across Canada and from the United States were present as guest speakers.

In addition to those pictured above the guests included Reverend Father Bertrand, President, Catholic Hospital Council of Canada; Dr. K. S. Ritchie, Department of Veterans Affairs, Ottawa; Reverend Father Fullerton, president, Ontario Hospital Association, and Mr. J. J. MacDonald, C.A. Montreal. Representatives of the federal and provincial departments of health, workmen's compensation boards, and the War Assets Corporation also attended.

Dr. R. J. Collins, Saint John, president of the Maritime Hospital Association, presided over the association meetings and Dr. J. A. McMillan, Charlottetown, over the Blue Cross sessions.

In his presidential address, Dr. Collins stressed the shortage of nurses which, he said, threatens to have a serious effect on the quality of service which hospitals are able to render and this at a time when demands on hospital space and service are rapidly increasing. In reviewing the work of the association since the last meeting Dr. Collins spoke of the study which had been made of improved systems of cost accounting and advised the delegates that the association was now prepared to serve any hospital requiring assistance in this respect. He went on to discuss the present shocking costs of hospital construction and maintenance and hoped that some assistance in construction might be procured

through low-interest government loans. This, he said, would depend upon the success of further Dominion-provincial conferences. In bringing his address to a close Dr. Collins traced the phenomenal growth of the Maritime Blue Cross plan and said that the association could well be proud of the development of this plan.

Advocates "Nurse Assistants"

Mr. A. J. Swanson of Toronto reported on the personnel situation across Canada and told the delegates that hospitals were being forced to close their doors for lack of nurses and other employees. He indicated that the Canadian Nurses Association was taking up the matter of training nurse assistants or aids by means of a concentrated nine months course which would give the trainees a definite status as assistants. He suggested that such a project would help to relieve the present crisis and expressed the opinion that governmental agencies should take steps to check the constant drain of hospital-trained personnel into industry and government institutions.

Hospital Rates and "Compensation"

Reverend A. A. Beaton of Sydney, reported on a brief presented to the provincial government on behalf of voluntary hospitals. He stated that no action had been taken by the government concerning the brief but that the Hospital Act had been amended to permit hospitals to charge the municipalities

Left to right: Mr. E. D. Millican; Mr. T. L. Doyle, Enrolment Manager, Maritime Blue Cross Plan; Miss Mary Sherwood, a Field Representative; Mr. D. O. Downing, Comptroller in the Maritime Plan; Mrs. E. D. Millican, Montreal.

$3.00 per day instead of $2.00 as hitherto for the care of indigents. This, Dr. Beaton said, would allow hospitals to increase their ward charges but, in reply to a question, he indicated that there was no assurance that municipalities would pay the increase.

Father A. J. MacIsaac, Inverness, led a lively discussion on the relations of the hospital with the Workman's Compensation Board. Mines Minister Currie indicated that the compensation rate of $2.50 per day would be raised to $3.00 but this amount is still inaedquate to cover costs. It was the opinion of several speakers that payment should be on a cost basis and not according to a flat rate as in the past.

The Department of Veterans Affairs also came under fire at this convention. It was charged that the Department refused to pay more than public ward rates for D.V.A. patients in general hospitals, knowing full well that these rates did not cover costs. It was also pointed out that the D.V.A. is taking nurses from the civilian field and hence was to some degree responsible for the present shortage. The question of whether the D.V.A. should undertake to train its own nurses was argued at length. The consensus was that this responsibility should be carried by general hospitals but that the cost of doing so should be covered by increased rates or by government subsidy.

Blue Cross Plan

At a session devoted to the Blue Cross Plan, the speaker was Mr. Richard M. Jones, public relations director for American Blue Cross Plans. He spoke of the tremendous upsurge of public interest in providing against the economic hazard of illness and noted that of 150,000 distinctly rural plan members in Canada, 80,000 were in the Maritimes. He congratulated this plan upon the exceptional progress made, particularly in the rural areas.

President of the Maritime Blue Cross plan, Dr. J. A. McMillan described the amazing spread of the plan idea as a striking example of democracy in action. Miss Ruth Wilson, executive director, in her report, stated: "Blue Cross is fast reaching the point where it is actually selling itself. Our main

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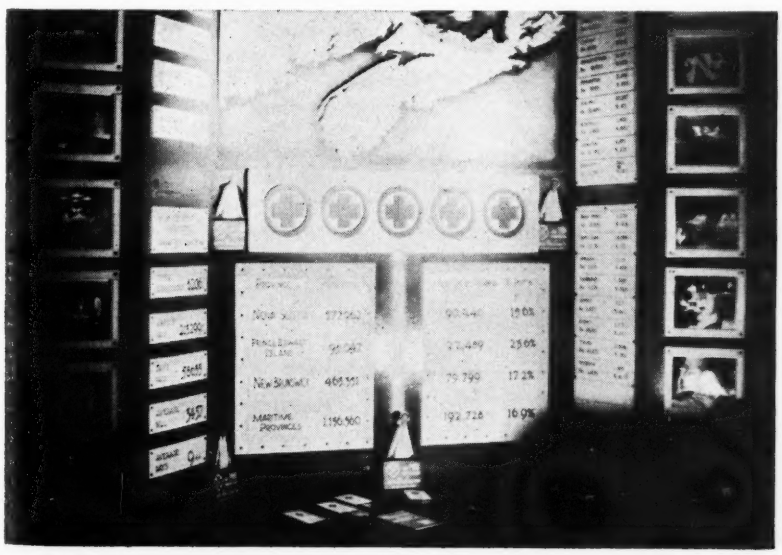


Exhibit of Maritime Blue Cross Plan at the convention.

Maritime Conference C.H.A. Convenes at Yarmouth

The 22nd annual convention of the Maritime Conference of the Catholic Hospital Association was held at Yarmouth on June 28th and 29th. Greetings from the Catholic Hospital Council of Canada were tendered by Reverend Father Bertrand, Montreal, president of that body. Sister M. Conchessa, superintendent of St. Mary's Hospital, Minneapolis, conveyed a message from the parent association and presented a paper on "The Evaluation Program in Action".

A discussion of developments in dietary service was led by Sister M. Irene, dietitian of the Halifax Infirmary and addresses on related topics were given by Mother M. Francis Loyola, superior, Sacred Heart Home, Charlottetown, and Sister M. Irene.

Sister Helen Angela of Washington, D.C., addressed the meeting on the subject of personnel. Other topics discussed were publicity and nursing education.

Among reports of standing committees were those by Mother M. Ignatius, superior general, Bethany House, Antigonish, on the Canadian Hospital Council; Mother M. Theresa, superior, Hotel Dieu de St. Joseph, Campbellton, publicity; Sister Paul of the Cross, superior, St. Joseph's Hospital, Glace Bay, ways and means.

New Officers Elected

President—Mother Saint Theresa of Campbellton.

Vice-president—Sister Mary Immaculata, Antigonish.

Secretary-Treasurer — Sister St. Stanislaus, Chatham.

Quebec Blue Cross Offers Comprehensive Plan

The Quebec Hospital Service Association submitted an Act to amend its charter at the last session of the provincial government. The Association requested power to enter into contracts with individuals or groups of individuals to provide, in addition to hospital care and treatment, medical, surgical, dental and nursing services. This Act was passed and received assent on March 28th, 1946.

With these additional powers the Association is now in a position to offer a comprehensive health service to the residents of the province of Quebec and it is hoped that the new contracts will be available before the first of next year. It is proposed to offer a contract covering *surgical care while in the hospital,* and an additional contract to provide *surgical and medical care in the hospital, home or doctor's office.* Contracts for *nursing services* and for *dental care* are being studied but will not be available for some time.

At the present time the Association is protecting approximately 250,000 persons under the semi-private hospital service contract and with the development of the additional coverage these members should be greatly increased.

While the rates and benefits have not been determined, they are being drawn up on the same basis as the Blue Cross hospital service contracts, that is, to provide the greatest care possible at the lowest cost.

The contracts will be administered by the present corporation, thus eliminating considerable expense in organization, duplication of records and personnel. The funds received from each service, of course, will be segregated and appropriate operating costs will be charged against each fund so that each contract will be self-supporting.

While the contract will be one of indemnity rather than service, an adequate allowance will be made towards the cost of the various procedures, the attending doctor having the privilege of rendering a supplementary bill if the amount received is not equal to his regular charge for such procedure. The medical profession has shown considerable interest in these proposals.

With the inauguration of this new service, medical-surgical plans, co-ordinated with Blue Cross, will be operating in three of Canada's nine provinces, namely, British Columbia, Manitoba and Quebec.

Maritime Meeting

(Concluded from page 49)

task will be to harness the enrolment to ensure satisfactory operation and continuity of membership".

Ladies Aid Association

Dr. R. J. Collins and Rev. Mother Ignatius both paid high tribute to the work of the Laides' Aids of the provinces both in helping to finance the hospitals and as a force in public relations. The Aids held a successful meeting at which about sixty delegates were present and Mrs. P. N. Woodley of Saint John was re-elected president.

Much credit for the success of the M.H.A. meeting must be given to Miss Ruth C. Wilson of Moncton and Miss Bartsch, Fredericton, who were in charge of the program, and to Mrs. Gladys Porter of Kentville, secretary of the association.

Dr. George F. Stephens, past president of the Canadian Hospital Council, who has not been able to attend hospital meetings during the past year due to illness, was warmly welcomed at Digby by his many friends and took an active part in the program.

Election of Officers

President — Dr. J. A. Clark, Charlottetown.

Vice-President—Rev. Mother Ignatius, Antigonish.

Second Vice-President — J. B. Sweeney, Saint John.

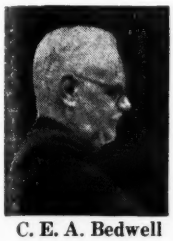
Secretary—Mayor Gladys Porter, Kentville.

Treasurer—Sister Catherine Gerard, Halifax.

Additional executive members elected were Rev. W. J. Gallivan, Antigonish; Dr. J. A. McMillan, Charlottetown and Dr. R. J. Collins, Saint John.

With the Hospitals in Britain

By "LONDONER"



C. E. A. Bedwell

Dear Mr. Editor:

England, like Canada, has its small hospitals, though I am not sure whether they occupy such an important place in the hospital system of the country. They certainly do not receive the same general recognition and, in particular, little has been heard about their contribution to the common endeavour in which we have all been engaged for five years. My attention was, therefore, naturally attracted to an account which came into my hands in the form of a neat little pamphlet of nearly fifty pages about "a little hospital in war time".

If you were to ask a man interested in hospital affairs what he would regard as a little hospital, he would at once describe to you the little cottage hospital, built and maintained by voluntary subscriptions, which is oftentimes the pride of the locality and has the active interest of the medical practitioners of the neighbourhood. But there is an entirely different type of little hospital, which has been developing especially during the years of war. It is under the care of the local authority and is technically known as a "public assistance" institution, though to overcome an inherited prejudice it may be renamed—as in the case of the subject of this narrative, which is Underwood House at Plympton in the county of Devon. The original building was erected nearly a century ago, though the hospital portion, with accommodation for thirty "chronic sick" is more recent. In addition there is a small maternity unit of three beds, making in all a complement of 133 beds.

Wartime Contribution of a Small Hospital

When danger loomed in 1939 the Ministry of Health decided that this little hospital should be "upgraded" and provision was made for a total of 251 beds. An operating unit was also provided, though it was not brought into use. Instead, before the war came to an end, the place became a sort of maid-of-all-work, which work was cheerfully undertaken by the resident staff, consisting of three men and nine women including the Master, Mr. Johns, and his wife, the Matron.

In providing an official record of what was done in this little hospital Mr. Johns has enabled the outsider to see what was involved in organizing these hospitals. For example, in the early days, the precautions against air raids became an important part of the work. It is not a small undertaking to arrange for the rapid removal of a number of helpless old people. So there were practices to familiarize the patients with the possibilities of what might happen to them. A careful record was kept of how long was needed to clear each ward without in any way causing physical or mental distress to the patients, and care was always taken in no way to arouse their fears. So on the signal "Clear Hospital" at 1 p.m. on the 1st of September 1939, sixty or more old chronic bed-lying patients were transferred to another little hospital further inland. This meant that letters were sent to notify relatives of the transfer and labels were prepared to give all the relevant information about the patient. Bags were got ready and the patients' little treasures and belongings tied up together in them. History documents were placed in named envelopes. Special first-aid kits were prepared for the nurses to carry whilst accompanying the patients to their new destination. At nine o'clock on that day the special buses arrived to take them to their destination and by midnight they were all settled in their new home.

So the hospital was emptied except for a small staff, but it had to make ready for anything or anyone who might come to it. The first obligation was carried out by blacking out two hundred windows, as there was not a blind or curtain to any one of them. Then supplies began to arrive for the additional Government beds, so that by the time war was declared on September 3rd there was something like a state of readiness for the extra patients.

But before the little hospital came into use in its proper function it had to pass through a number of other experiences. In the vast scheme of rest centres, which had to be established in all areas, this little institution became a pivot. Plymouth was a fair enemy target and, as an area where people might take refuge, Plympton provided for thirty thousand persons. It was not only civilian evacuees who came within the hospitable range of the staff. Two Guards' Divisions, the vanguard of the first British Expeditionary Force, arrived late one evening before any arrangements were in operation for canteens and were sent on their way refreshed. A few weeks later fifty men of a heavy Artillery Unit working in the neighbourhood were driven by the bad weather to find indoor accommodation. They were put up in the hospital and thirty of them who were suffering from influenza and sore throats had actually to become patients.

As events developed on the Continent this little hospital was called upon to take on quite another task. On the 20th of June, 1940, there arrived three hundred bedraggled, unkempt, exhausted and weary though excited refugees, among whom were French, Poles, Czechs,

Spaniards and Moroccans. Next month some of our own people from the south-eastern end of the coast were seeking refuge. On July 5th one hundred old people arrived in buses at 11 p.m.—in the middle of a raid, so that they wondered whether their last state was any better than their first. No sooner were the old ladies settled in than civil defence requirements led to more than one hundred men of the Royal Marines being assigned billets on the premises. They were followed by detachments from other regiments and, when London was feeling the full force of the enemy attack, twenty-five old ladies arrived from Stepney. About this time everyone was cheered by the arrival of gifts from the Canadian Red Cross and at the time of my visit I was shown some of the more dainty preserves which were still being used to relieve the monotony of post-war diets.

At the end of 1940 and the beginning of 1941 Plymouth had its worst time. It is very difficult to make comparisons, but there is general agreement among observers that Plymouth was among the principal cities of the kingdom to suffer from the fury of the attacks. The result was that Underwood House found itself with a larger resident population than at any previous period in its history. There were over two hundred patients in the little hospital with a normal capacity of 130. Besides this there were approximately one hundred troops and the staff, which, however, had been little increased to provide for the additional numbers.

The attacks on Plymouth led to an entirely different appeal to the little hospital. The Corporations headquarters in the Guildhall were entirely destroyed and the City Treasurer was anxious about his records, so he asked if they could be stored at Underwood House. The message indicated a few documents but they arrived in a double-decker Corporation bus with top and bottom decks piled high and were followed by three or four more buses!

The task of providing for the population, who were suffering considerable hardship at this time, was even more exacting and for days and nights on end the staff had hardly any rest. One night five thousand people are said to have fled from Plymouth into Plympton.

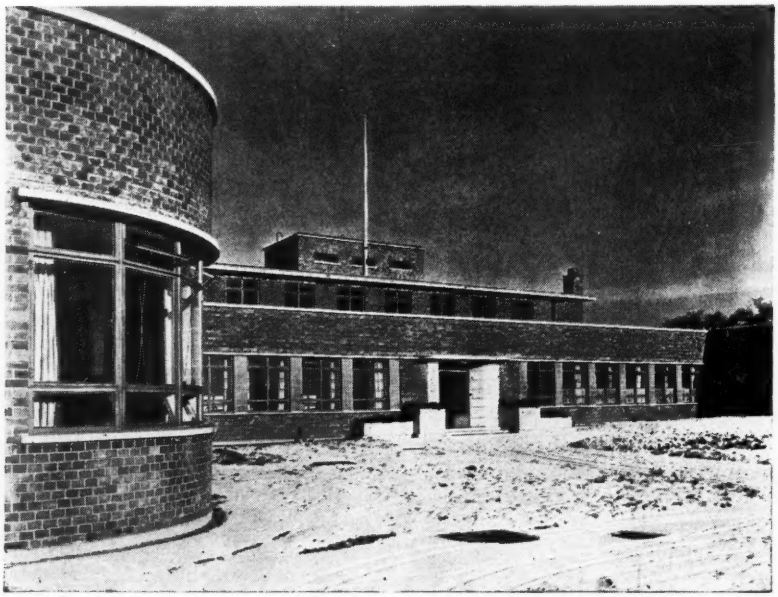
In the spring of 1942 the hospital was made to take up some of the work for which it had originally been prepared, and thirty patients were received from the Exeter City Hospital when that building was partially destroyed by fire.

The little hospital itself suffered from blast and incendiaries, though not sufficient to lead to any cessation of work. To it was allocated a place in the forward movement as arrangements were made for the troops to cross to Europe, and Underwood House became an emergency unit of the American 115th Station Hospital.

Before the end of hostilities, however, the hospital received another consignment of patients from London who had been victims of the flying bombs. Forty came from St. Clement's Hospital, Bow, the average age being seventy-nine.

On the whole this narrative may be regarded as typical of the experiences of similar institutions which were within the range of the enemy's activities. But the way in which they have risen to the occasion is opportune in drawing attention to their possible contribution to the future national hospital service. In particular domestic difficulties of the present time are widening the range of the population from whom they draw their patients. The old poor-law workhouse with its attaching stigma has gone for good, it may be hoped, and in its place we have a comfortable haven or rest for those who have been accustomed to some of the amenities of this life. At the time of my visit to Underwood House there was living in it the widow of a Canadian Naval Officer still receiving her pension from Ottawa, and not long before another similar widow had died there.

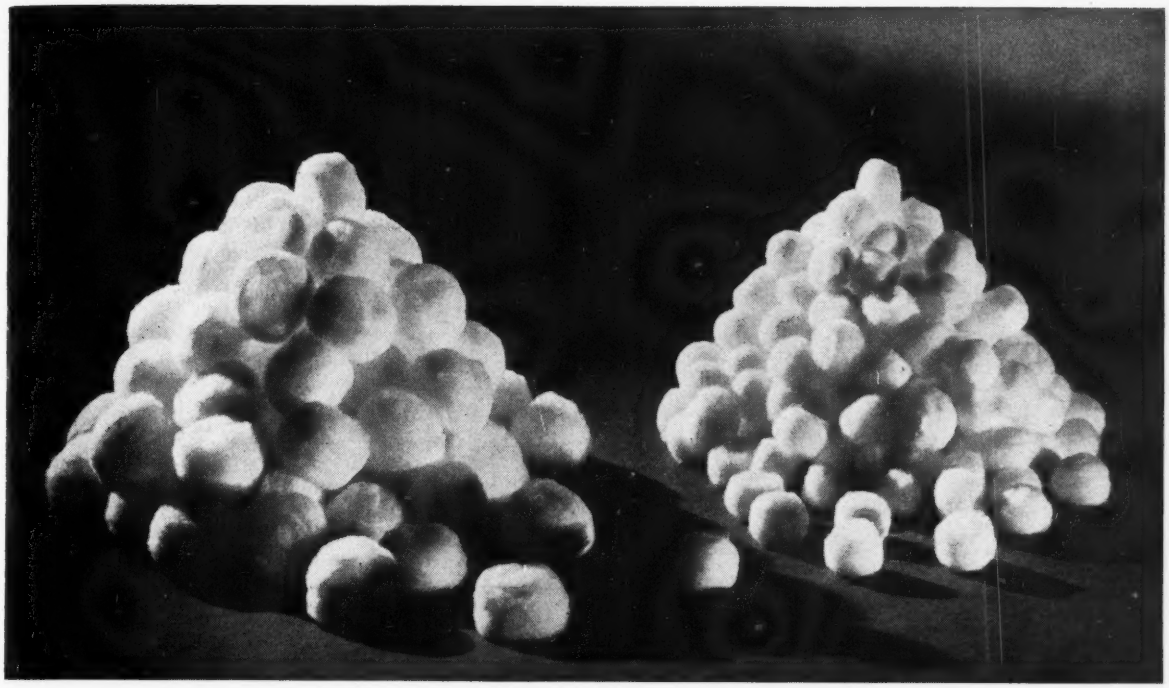
Sharing in the experiences of Underwood by acting as a relief on several occasions is a similar institution in the little town of Okehampton, about thirty miles away. There I found a matron born in the city of Toronto, though her family returned to England before she was able to begin her training as a nurse. Her testimonly presented another espect of the development of these hospitals. There is a marked increase in the interest of the people of the place in the little hospital and its patients and a readiness to brighten their lives by visits or receiving them into their own homes. May I add that these two visits to little places tucked away in the country illustrates the extent to which Canadian associations are taking their place in the life of this country.



Modern Small British Hospital

One of the many small hospitals being erected in Great Britain. This is at Potters Bar, near London, although the snow would suggest a Canadian location. The building, with its large windows and deck space, is typical of Britain's modern smaller hospitals.

——British Council, O.S.P. Dept. Photo.



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Role of the Hospital

Group Practice Has Many Advantages

From a Study by the Commission on Hospital Care

GROUP medical practice is the application of medical science by a number of physicians working in systematic association and having joint use of equipment and technical personnel, with a centralized administrative and financial organization. The co-ordinated efforts of a group of physicians can provide the individual patient with medical care of a higher calibre than is possible by equally skilled physicians working separately.

Since World War I there has been a growing trend toward group practice in medicine. That war provided a stimulus to the movement in that a great many physicians were exposed to the idea as a result of their military service. There are many indications that the experience obtained in World War II will give additional impetus in this type of medical practice. When the system has failed, the fault in most instances has been in the organizational structure, the division of income and expense or in antagonism on the part of the profession.

The development of specialization in medicine continues to foster the trend toward group practice. Further impetus was given during the last decade by the development of prepayment plans for medical care and hospital service which are readily adapted to this form of medical practice.

With proper organization, agreement among the members of the group as to financial matters and control of quality of service and other relationships, group practice should be of far greater value to the public and the profession alike than practice by the physician working alone.

Relation to the Hospital

An essential feature in the development of group practice in any community lies in providing adequate quarters to house the offices of physicians, their technical assistants and the equipment for diagnosis and treatment. General hospitals should be the headquarters for all types of medical practice. By providing the facilities required for complete medical care they can become the centre about which professional services can be organized in such a way that the benefits of group action would supplement the efforts of individual practice.

The methods of group practice have been applied in the provision of medical service to indigent patients in the wards of hospitals. However, this system has not been expanded to include service to regular paying clientele in most instances. When the merits of group practice have been recognized as desirable for one group of patients, it would seem logical to apply the method to all patients. It is believed that the formal organization of group practice units in general hospitals could be effected easily.

In some areas, the hospital has become the headquarters for a highly efficient and economical medical service in the community through group practice arrangements. Facilities are provided for doctors' offices in or directly adjacent to the hospital. Methods have been worked out for the common use by all physicians of personnel and equipment and thus unnecessary and costly duplication of facilities and effort have been eliminated. Under such arrangements, there is often a sufficient volume of work to justify employment of more highly trained and skilled technicians.

Doctors, having ready access to complete facilities for diagnosis and therapy, are saved a great deal of time in travel between office and hospital and also have expert professional advice available for consultation in special cases with a minimum expenditure of time and effort, particularly on the part of the patient.

Although primary interest in this regard centres around the voluntary hospital, it should be pointed out that governmental medical service as provided in institutions operated by the military services, the Veterans' Administration and in many state, county and municipal hospitals is based on organized group practice methods.

However desirable it may be to centre group practice in and around a hospital, this is not the only approach to the problem. Some successful groups of physicians have found it necessary to provide for their own needs—building, equipment and personnel. But regardless of the methods selected for providing facilities, it is necessary that a certain amount of the physicians' time be spent in a local hospital. Each doctor who is a member of the group must have a staff affiliation with a general hospital in which he can hospitalize patients requiring surgery or extensive medical therapy. It would seem, therefore, that organization of the group around the hospital would contribute most to the effectiveness and efficient operation of the program.

Advantages Summarized

The same number of men can serve more patients because of time-saving economies effected through the close association of doctors proficient in the special fields of medicine. The results of x-ray examinations, laboratory tests and examinations made with special equipment and instruments are readily available. Consultation between members of the group

(Concluded on page 74)

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Here and There

By the Editor

Experiencing a "Waterquake"

What with cyclones, tornadoes and earthquakes this summer Canada is getting more like its neighbours every year. Most of us have felt a few tremors at times, some of them fairly severe, with rattling dishes, falling chimneys and other evidences of the subterranean disturbance. But the writer had never had the experience hitherto of going through a fairly sharp quake while in a boat.

The earthquake which shook up Port Alberni, Courtney and other places on the west coast of Vancouver Island occurred at about 10.20 a.m., on Sunday, June 23rd. At that time the writer was with the captain and mate in the wheelhouse of the little 70-ton boat which plies the 28-mile inlet connecting Port Alberni with the open sea and the various villages and camps en route. (Why this magnificent winding fiord, flanked by 1000-foot, and higher, mountainous banks should be dubbed a "Canal" in this era of tourist-seeking publicity is hard to understand). The boat was suddenly jolted and thumped as though it had gone up on a rough, but not rocky, shoal; yet where we were the water was 200 fathoms deep. The diesel engines missed badly, probably due to the jarring, and the captain turned them off quickly, suspecting a bent propeller shaft or other injury. The striking of a huge log and the resultant loss of a propeller blade also seemed possible. However, when the engines were again started, cautiously, they seemed quite normal and no deadheads or submerged hulk appeared in our wake. A couple of minutes later, the captain looking up a small lateral bay saw a peculiar ground swell coming out from shore —an unheard-of phenomenon at that point so far inland. That gave Captain Young his diagnosis: "Only one thing could do that—an earthquake!" At noon this was confirmed when we put in at Bamfield, the cable station on the coast. Incidentally, Captain Young, an ex-naval officer, is the son of the late Dr. H. E. Young, for many years the Provincial Health Officer for British Columbia.

A good deal of damage was done in that general area. Quite a few chimneys came down; several public buildings were declared unsafe; some plaster was down in my hotel room on my return. Numerous rock slides occurred and, at one fishing village visited, considerable damage was done to waterfront buildings and the main wharf. At one of Port Alberni's largest lumber mills it was ironical that, having resumed work just two days earlier after a month's closure due to the loggers' strike, the plant should again be shut down due to severe damage to its boiler plant and the throwing of its saws out of alignment.

* * *

More Competition for Interns

Starting July 1st, 1947, new arrangements have been worked out for the appointment of junior interns in U.S. Army hospitals. After that date interns selected will be given a reserve commission as first lieutenant in the Army Medical Corps, and as such these interns will receive from $2,972 a year to $3,404 annually, depending upon whether or not there are dependents. These figures include rental allowances of about $60 a month, which are not paid when government quarters are furnished. It will be expected that these interns will accept Regular Army commissions upon completion of these clinical internships. They are only open to United States citizens.

* * *

A Truant from Medicine

William Findlay, 1846-1917

Prior to the year 1898, when for the first time the real name as well as the pen-name of the author appeared on the title-page of *Robert Burns and the Medical Profession*, few of his readers realized that "George Umber", whose contributions to the *Kilmarnock Standard* were as eagerly anticipated as was the appearance of a new book from his pen, was Dr. William Findlay of Dennistoun.

Born at Kilmarnock, Ayrshire, on January 31, 1846, the son of an engine keeper and of the sister of a local poet Archibald McKay, Findlay became in 1866 a medical student at Glasgow. There he sat at the feet of Andrew Buchanan of blood coagulation fame, of Sir William Tennant Gairdner, and of the great Lister. Graduating M.B., C.M. in 1870 and M.D. eight years later, he practised for many years in Dennistoun, a suburb of Glasgow, until an attack of coronary thrombosis in 1906 forced him to retire into the country. At Kilbride, he devoted the remaining ten years of his life to the pleasant pursuit of literature. He died on May 11, 1917.

In his writings, both poetry and prose, William Findlay is revealed as a man of shrewd and kindly judgment and of keen and ready humour.

The following few verses from his poem, "Therapeutics o' Gowf", may serve as an example of his lighter poetry:

"Ye say ye need a tonic rare?
Then o' the doctor's shop beware,
Your hauf-croun spen' in railway fare
To some gouf shore;
A dose o' Prestwick's champagne air
Ye'se quick restore.

"Gowf can do ought ye like to say—
The auld turn young, the dull mak' gay,
An' noweel facts an' fancies slay
As deid's a mauk;
It's worth a hale vacab'lary
O' doctor's talk."

W. R. Bett, M.R.C.S., F.R.S.L., F.R.S.A. in Post-Graduate Medical Journal.

Braided for non-slip knots . . .
. . . black for identification

. . . Black Braided NYLON SUTURES

Surgeons who prefer Black Braided Nylon — for its firm, non-slip knots — for its visibility in tissue — find these important characteristics in Ethicon:

1 — Ten diameters in compliance with U. S. P. silk specifications (5-0; 4-0; 000; 00; 0; 1; 2; 3; 4; 5: all in 25-yd. spools).

2 — Maximum tensile strength (in excess of U. S. P. requirements for silk) both straight and knot pull, in any given size-designation.

3 — Color-fastness during sterilization and in tissues.

4 — Moisture and serum-proof; non-irritating; non-capillary even after sterilization.

5 — Uniform braiding to assure smooth knots.

These characteristics make Ethicon Black Braided Nylon* the outstanding suture material where use of braided nylon is indicated.

***HOSPITALS** also find these 2 important features of advantage:
Free reels are supplied with each spool for sterilizing cut lengths . . . a great time saver for nurses;
Economy results because these 25-yd. spools may be combined with Ethicon Braided Silk to earn quantity prices.

ETHICON Sutures

Finer Sizes For Every Surgical Procedure

SUTURE DIVISION
Johnson & Johnson
LIMITED MONTREAL

Plastic Tableware

for Hospital Use

By FRANK ROUTLEY,

LIKE so many other sensational developments which had their birth during the stress and struggle of wartime industry, plastic tableware has only recently appeared in its true perspective as a staple everyday product in its own right rather than a wartime substitution. The many advantages of this type of tableware are becoming more and more generally appreciated and the increasing demand for durable dishes has stimulated mass production for commercial use.

The finest type of plastic tableware today is made from *melamine*, a specially compounded raw material which was developed to meet the rigid demands of the United States Armed Forces and almost immediately came into use in Canada as well. Plastic dishes are made from *melamine* by the process known as compression moulding. This consists in placing the raw material in heated steel moulds and applying pressures exceeding 3,000 pounds per square inch by means of hydraulic presses. As the raw material enters the steel mould a softening, or what is termed "plasticizing" reaction takes place. With the application of tremendous pressure the mould is completely filled and closed under temperatures ranging from 300° to 400°F. The material is held in this position for a predetermined period of from one to several minutes, depending upon the particular product involved, and undergoes a baking or "curing" operation. It is then removed from the mould and, after cooling, is rapidly passed through the subsequent testing, finishing and packing operations preparatory to shipment.

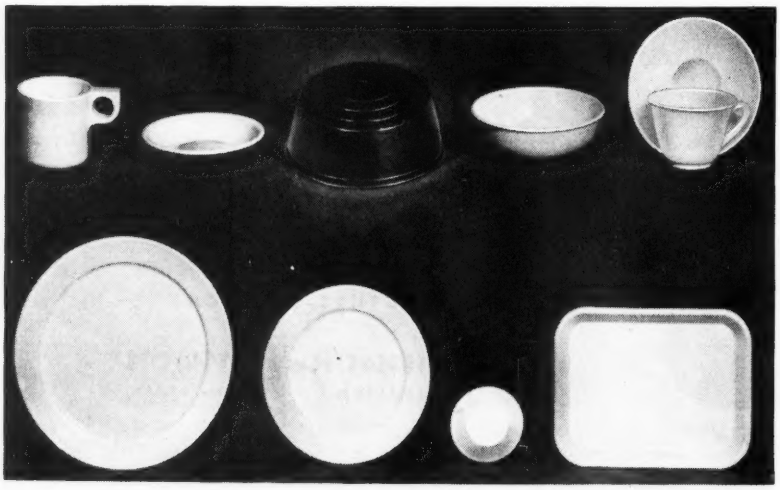
During the moulding process *melamine* plastic material undergoes a chemical reaction and becomes permanently set to the desired shape. Subsequent applications of heat as required under normal dishwashing procedures finds the product entirely odorless and tasteless as well as completely heat resistant and warp proof. These qualities were unobtainable with earlier plastic materials.

Plastic tableware is being produced in many attractive pastel tones, e.g., coral, yellow and green. This variety in colour is particularly valuable in hospitals and other institutions where it is desirable to ensure that the same tableware is kept exclusively in a particular ward or division for the prevention of contamination, or simply to facilitate the checking of supplies. Contrasting colours in this type of tableware have been chosen by the Ontario Department of Health for its various institutions, by many military and civilian hospitals and by Federal penitentiaries. The Canadian Navy has approved plastic dishes, has indicated a colour preference and recently purchased large quantities for ships' stores. As the colour range in plastics is practically unlimited, it is to be expected that with the return of normal raw material production even greater variety in colour will be available.

The functional stability of plastic tableware, as reported by various customers, is followed very closely by the manufacturers. As a result certain improvements both in design and technique, demanded by commercial requirements, have been developed and these are reflected in the increasing volume of orders. One of the recommendations brought out in this way and which should be drawn to the attention of all consumers is that the normal life of plastic tableware is immeasurably lengthened by restricting the time of immersion, during dishwashing, to a minimum. Many authorities substantiate this practice, for it is generally known that at the proper dishwashing temperature any bacteria or germs which are present are eliminated shortly after immersion and longer periods have little or no effect. It may also be noted here that tannic acid stains which develop in practically all types of tableware may also appear in plastic dishes. However, this problem may be reduced to a minimum if the operator adopts the practice of treating the tableware to a semi-weekly bath in chlorine or other commercially approved compound designed for the prevention of staining.

There has been a lingering impression generally prevalent that a certain taste and odour were inherent in plastic dishes but it is now an established fact that tableware made from *melamine* is entirely odourless and tasteless.

Although Canada is now using most of the plastic tableware produced here, shipments have been made to customers in many other countries who are interested in its unusual qualities and have offered ample testimony to its merits.



Tableware made of melamine is manufactured by Maple Leaf Plastics Limited, Toronto.

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DESIGNED FOR SERVICE

Modern Hospital furniture, besides providing the utmost in comfort for patients should embody such necessary features as:

Light, sturdy construction
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Long-wearing service
Good appearance
Easily cleaned surfaces

These characteristics are found in each unit of Metal Fabricators Equipment. Welded steel joints make for lightness; steel tubing eliminates dust-catching cracks and roller-drawer slides operate silently with finger-tip control.

SPECIAL INSTALLATIONS PLANNED FOR:

Instrument cabinets
X-Ray view boxes
Blanket, solution and utensil warmer
Nurses' stations

New developments enable us to match any wood finish, as well as standard plain finishes.

Metal Fabricators LIMITED

TILLSONBURG ONTARIO

A Canadian Hospital Film

"Western Hands Are Sure"

THE work of a rural hospital in Alberta and its famous chief surgeon has been featured in a new 16mm. sound film in colour being released by the Committee on Missionary Education of the United Church of Canada. This dramatic story of pioneer medical work in a rural community makes a valuable record of the earlier days of medical practice in the outlying parts of Alberta and its progress to the fine facilities available today.

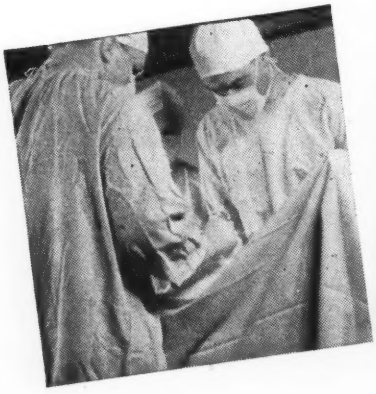
Inevitably, the story follows the forty years of service which Dr. A. E. Archer, past president of the Canadian Medical Association, has given to the large group of European-Canadians in the area. The early scenes show Dr. Archer as a young intern in Hamilton receiving a letter from Dr. Harry Smith who had begun to practise at Star, Alberta, the year before Archer graduated at Toronto. He and his bride, a graduate of the School of Nursing at the Hamilton General Hospital, are then seen arriving at Star. Early experiences in which patients were visited over incredibly bad mud roads and operations were performed under very primitive conditions are followed by the laying of the railroad through the area and the doctor's moving to Lamont.

Then follows a scene depicting the meeting called in the community to consider the building of a hospital. The picture shows the growth of the hospital from that first unit to its present status of 65 beds. It introduces the School of Nursing and three graduates; one a Canadian-born Chinese who distinguished herself in Hong Kong; another who won the Kaiser-I-Hind Medal for services to the Indian Army in the recent war; and a third who started a training school for nurses in Korea.

The public health work of the hospital is shown by flash backs to the early attitude of the community, contrasted with the existing situation where Lamont is the centre of an Alberta Government Public Health Unit.

The story on the whole is a convincing presentation of the power and influence of a Church hospital.

—K.J.B.



Correspondence

A Challenge to Selkirk

To the Editor:

We, also, do not wish to boast but believe our record is slightly ahead of that of the Selkirk General Hospital, as reported in the July issue of *The Canadian Hospital* (page 72).

On May 30, 1946, between the hours of 12.15 p.m. and 5.20 p.m. (which, alas, was also the day of graduation), our baby record was six—six in five hours—two girls and four boys. Two were twin boys.

Moreover, we say nothing of the other babies born during that 24 hours.

In that same month 54 babies were born in the hospital; yet we are supposed to have only eight beds for maternity cases in our 60-bed hospital. Our patients all come from the local urban and rural areas as there is neither an airport nor naval or military camps here.

Yours truly,
Margaret Jamieson, R.N.
Superintendent,
Prince County Hospital,
Summerside, P.E.I.

£74,000 Endowment of University Chair

The University of London has accepted an offer from the trustees of the estate of the late Sir Harry Wellcome of a capital sum of £74,000 for the endowment of the Chair of Pharmacology tenable at the College of the Pharmaceutical Society and henceforth to be entitled the Wellcome Chair of Pharmacology. The income will be used to pay the salary of the holder of the chair, now occupied by Professor G. H. Buttle, and to contribute to the cost of the research work.

Professor G. H. Buttle, O.B.E., joined the staff of the Wellcome Physiological Research Laboratories in April 1926 and was responsible for the early developments in work on the chemotherapy of the sulphonomides at Beckenham. Later, in the Royal Army Medical Corps, he did brilliant work in providing blood for resuscitation in the North African campaign.

Oxygen Therapy At Home

Oxygen therapy is frequently prescribed for angina pectoris and other ambulatory cardiac patients, asthmatics, severe migraine sufferers, pulmonary emphysema cases, and others afflicted with chronic conditions not requiring hospitalization, but yet benefited by oxygen inhalation for periods lasting an hour or more at a time.

When prescribed, the patient can easily be taught to administer the treatment himself. It is important, that the equipment be perfectly comfortable and that the patient be entirely familiar with its correct operation. Types of apparatus and current operating techniques are described in the Oxygen Therapy Handbook, available without charge on request.

The nasal-type mask illustrated is only one of the several types of masks, face tents, and nasal inhalators available for self-administration of oxygen. DOMINION Oxygen B. P. can be obtained locally from Dominion Oxygen distributors.

DOMINION OXYGEN (B.P.)

OXYGEN THERAPY DEPARTMENT

DOMINION OXYGEN COMPANY, LIMITED

159 Bay Street DOC Toronto 1, Ontario

"Dominion" and "DOC" are trade-marks.

Colour Conditioning

(Continued from page 37)

Smaller offices are frequently crowded with both personnel and equipment, and are apt to give the occupants a "hemmed-in" feeling. A light colour such as ivory will increase the apparent dimensions of such rooms and will reflect light more completely to all its corners.

More scope is found in large, well-lighted executive offices where individual taste can be considered. Greys, greens and blues are favoured because they create an impressive appearance and they contribute to a cheerful and refreshing atmosphere. Green, for instance, is a subtle tone lacking in monotony—it will appear yellowish under artificial light and bluish under natural light. Therefore, it is appropriate for interiors occupied for long periods of time. A tip for those who want to look their best—certain greens also happen to be the direct complement of human flesh and tend to enhance the normal tint of human complexion.

Dimensional changes can be effected through the use of colour. The length of a long, narrow office can be reduced by painting either one or both end walls in a darker colour, and the painting of the trim in the same colour will unify the room. This same idea can be used in an executive's office. The executive can be made the focal point in the room by painting the wall back of his desk in a colour that is in contrast to the other three walls.

In every general office there are many eye distractions: tables, desks, chairs, radiators, file cabinets, door frames, baseboards, picture mouldings, ornaments and other appurtenances. Get your beauty from the wall colour and promote uniform seeing conditions by painting all these other items in the wall colour or a slightly deeper tone.

Other Rooms

Reception rooms and lounges should be in cheerful and restful colours conductive to relaxation for those who may have to wait for irregular periods. Ivory side walls with tan, grey or natural wood trim are suitable.

File rooms are usually drab places. The upper walls should be painted in a light stimulating colour. Usually equipment is non-uniform in shape, size and character. This should all be painted in a light but serviceable colour. If this is not possible, a dado on the walls in a colour that is similar to that of most of the equipment, and as high as the top of the equipment will serve as a camouflage.

In selecting colours for rest rooms and washrooms merchandising statistics are a reliable guide, and these show that women's preferences are for colours like rose, pink and peach, whereas men favour blue, blue-green or blue-grey. Such rooms may be painted in pleasing combinations of colours that promote cleanliness and sanitation.

Halls and stairways are places of activity. They can be made lighter by the use of bright yellow tones on the upper walls. Stimulating colours are permissible in such areas because they are traffic ways, somewhat noisy and bright colours have directional value.

Cafeterias should be finished in colours that are considered "appetizing". Peach is a favourite colour; so also are beige, rust and tans.

Storerooms have irregular traffic. Brightness and visibility can best be obtained in them by painting the walls white with a dado of tan or grey.

Machine Shop

The same principles apply to the painting of the ceilings, walls, floors and equipment in the shop as have been followed in the offices. All ceilings should be painted white. The upper walls should be painted in high light-reflecting colours that have been "greyed" so that they are non-stimulating. Workers who are concentrating for long periods at tasks that require close attention and extreme accuracy do not want to be distracted by stimulating colours. The dado should be serviceable but light-reflecting, and it should combine with the upper walls to present a contrast background both for the machines and the work being done.

Floors should be painted in light reflecting colours. In most plants, floors are allowed to become light robbers. If nothing better can be done, at least the area immediately beneath each machine should be finished in a light-reflecting floor enamel, so that light is reflected upwards to the under parts of the machine and thus facilitates its operation. Good housekeeping and safety naturally results from this improvement because the workmen will keep the machine and its vicinity clean and tidy.

Even the machinery must be used as a light reflecting surface to contribute to the general seeing conditions. Here the principles of brightness and engineering are used in the recommendations of *Three Dimensional Seeing.* A mistake to be avoided in painting machinery is that of overdoing it. There is a tendency to overlook the cardinal fact that a machine is a production tool, and to paint it in fancy colours is to give it a misleading appearance and an excessive brightness which may discourage the worker entirely. At the same time, any parts exposed to constant soiling and abuse may soon appear shoddy if the colour treatment is too delicate. Too many colours used to identify working parts create confusion and defeat the functional purpose of colour. Time study and reaction tests were therefore made to determine what were the two best colours to use on machinery and it was found that a medium grey and a light buff made a pleasing combination and offered the sharpest desirable contrast. Buff separated the working area from the rest of the machine and exposed the danger points; it increased the visibility at the working level and supplied a contrasting background for the material being processed. This reduces eyestrain and loss of time and material through spoilage.

When the machine is finished in the "Three Dimensional Colours", with a light reflecting floor, and is clearly visible against a contrasting wall colour, the workman does think in three dimensions — colour, light and safety.

Safety Colour Code

Colour conditioning also includes the Safety Colour Code. In every industrial plant there are unusual or unexpected conditions which may cause injury to new employees or those lacking in alertness on account of fatigue or worry. There are also times when repairs are undertaken with no certainty that all of the staff know of them. There is always emergency equipment which should be instantaneously recognized. The Safety Colour Code assigns a colour to each of six purposes, and suggests

(Concluded on page 82)

Relaxation without deep anesthesia

Administered intravenously, Intocostrin promotes safety by producing abdominal relaxation without deep anesthesia. The intestine is contracted and a quiet abdomen produced. Action is rapid, profound, and brief. In therapeutic doses there are no effects on involuntary or cardiac muscle,[2] no untoward postoperative complications. Intocostrin has been used to advantage with cyclopropane, ether, nitrous oxide, ethylene and sodium pentothal. It is a purified, standardized extract of curare (*chondodendron tomentosum*) which produces muscle relaxation through a readily reversible myoneural block.

(1) Cullen, S.C.: Anesthesiology 5:166 (March) 1944.
(2) Griffith, H.R.: J.A.M.A. 127:642 (March 17) 1945.
(3) Griffith, H.R.: Canad. M. A. J. 50:144 (Jan.) 1944.

For literature write E. R. Squibb & Sons of Canada, Limited, 36-48 Caledonia Road, Toronto.

Intocostrin

TRADEMARK

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Awards in Administration

Elmer W. Paul and Elizabeth Jane Davis receive Malcolm T. MacEachern medals from George A. Kellogg of Johnson & Johnson Research Foundation, as top rankers in first graduating class in hospital administration at Northwestern University, Evanston, Illinois. Looking on are Professor Myron H. Umbreit (centre) and Dr. Malcolm T. MacEachern, director of the courses. The awards were presented at an Honours Convocation in the auditorium of the American College of Surgeons on June 21st. Degrees of Master of Hospital Administration were conferred upon Mr. Paul and Mrs. Davis and four other graduates, and the degree of Bachelor of Science in Hospital Administration upon two graduates on June 19.

Hospital Fire Precautions

IN case fire should break out in the hospital, it is necessary to provide a well-defined system for (a) giving the alarm by the person discovering the fire; (b) rousing the sleeping patients and staff likely to be affected; (c) calling the Fire Service; and (d) taking emergency steps pending the arrival of the Fire Service. Unless all these things can be done by the same person, it is also necessary to provide for (e) summoning the help of other persons, (e.g. a Fire Officer who should be a resident member of the hospital staff in charge of inspections, drills and appliances) and making sure that the summons has reached the persons concerned. The order in which these should be done is a matter for consideration by hospital authorities but the Fire Service should always be summoned as soon as possible.

In arranging the method for alarm, it is important to bear in mind that the patients should not be unnecessarily startled. At the same time, however, the fire alarm, whatever system may be adopted, should be so arranged as to rouse the staff in all parts of the hospital likely to be affected. Officers should be detailed to go to the various wards in order to allay any tendency to panic.

Alarm Apparatus

For the purpose of rousing staff an alarm system should be provided either (a) by an electrically operated fire alarm of the press or release button type, with a sufficient number of call points installed in suitable positions throughout the hospital, the bells being placed where they will disturb the patients as little as possible but summon the staff, or (b) by a similar system of hand-operated fire bells. In conjunction with an electrically operated fire alarm system, an indicator board should be installed in a convenient position. This apparatus would be in charge of the Fire Officer mentioned above.

Immediately an alarm is given the attendant should transmit the call to the Fire Service without waiting to ascertain whether the hospital fire appliances will be sufficient or not.

Printed instructions should be displayed, indicating the various means of summoning the Fire Service.

In any case, some person should be stationed at the entrance of the hospital to direct the firemen to the scene of the outbreak with the least possible delay.

Other Essential Steps

Arrangements should be made for a responsible official to be informed at the same time as the fire service is summoned so that he may direct operations until the arrival of the Service.

Upon the discovery of fire all doors and windows in the vicinity should, as far as possible, be kept closed in order to exclude draught.

If hydrants are provided, hose should be extended from the nearest one, care being taken to keep the hose free from kinks; but the water should not be turned on unless it is evident that the extinguishers and fire-buckets are insufficient to extinguish the fire.

If the fire is of an electrical nature, sand only should be used in the first instance, and the current should be cut off.

In the event of oil, spirit or fat fires, foam type extinguishers should be used. When a person's clothing is alight, or if the fire is small, wraps, blankets, rugs, etc. should be used.

Nurses on duty should move patients from the proximity of the fire, or, if necessary, evacuate the ward. Patients may be removed on bedding if this is essential but beds or other furniture should not be moved.

Officers who have been detailed previously for the purpose should go directly to the various wards, etc., while the remainder of the staff should go to whatever stations have been allotted to them or should leave the building.

—From a Memorandum prepared by King Edward's Hospital Fund for London, April, 1946.

for schools

The steady tramping and scuffling of children's feet have little effect on a linoleum floor.

hospitals

Restfully resilient, linoleum absorbs sound and is easy to keep clean and sanitary.

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Clean, colourful linoleum adds to the display value of merchandise, while its foot-easy resilience appeals to customers.

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Smart in appearance, quiet and comfortable to walk on, linoleum wins approval of staff and clients alike.

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FOR the floors of public rooms, linoleum is the preferred choice. It can always be kept spotless, for it's quickly and easily cleaned. An occasional waxing, with light moppings in between, and it stays in perfect condition through the years.

Linoleum maintains its fine appearance indefinitely no matter how heavy the foot traffic upon it—with the minimum of upkeep cost. It's a pleasure to walk on, too, for its unequalled resilience cushions the feet.

Linoleum is the ideal floor specification for busy buildings. Consult your architect or linoleum dealer for ideas and suggestions, and see the wide range of attractive colours and patterns.

Supplies are still limited, but it's not too early to plan.

DOMINION OILCLOTH & LINOLEUM
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Provincial Notes

(Concluded on page 68)

British Columbia

MISSION CITY, B.C. The proceeds from the annual strawberry festival at Mission City were this year given to a fund for the construction of a new wing at Mission Memorial Hospital. It was a gala day in the town, the strawberry queen being crowned on a stage built in the shape of a bowl of berries and the succulent berry on sale everywhere. A model steam-powered train ran through the main thoroughfare which was closed to other traffic. There were also log bucking contests, a variety of games, folk dancing and a street dance at night.

* * *

VICTORIA, B.C. The new 87-bed maternity wing of the Royal Jubilee Hospital was formally opened in June. Mr. G. H. Stephens, president of the Hospital Board, speaking before the ceremony, said the building fulfilled a 50-year ambition of the directors and was the most up-to-date maternity hospital in Canada.

* * *

SUMMERLAND, B.C. A bylaw has been passed providing for the construction of additions to the present hospital here and plans have been prepared by Gardiner and Thornton of Vancouver. A two-storey maternity wing with operating and case rooms will be built as well as a two-storey nurses home. The cost is estimated at $60,000.

Alberta

LAMONT, ALTA. The United Church Hospital at Lamont is to be enlarged and extended. The executive of the Board of Home Missions of the United Church has decided to give $50,000 toward the project, lend $50,000, and leave the other third to be raised by the community and by the United Church constituency in Alberta. Especial attention will be given to the training of nurses for missionary service.

Saskatchewan

ARCOLA, SASK. Excavation for the basement of the new nurses' home of the Brock Union Hospital at Arcola (which was accomplished by voluntary labor with the assistance of five tractors) is completed. The building is expected to cost about $8,500 and erection will begin immediately.

* * *

SWIFT CURRENT, SASK. The City Council will petition the provincial government to declare a union hospital area centering on this city and comprising six other rural municipalities and three villages, requesting that the proposed hospital be erected here. The area has a population of about 18,000, with an assessment of some $19,000,000.

* * *

WHITEWOOD, SASK. Plans are under way for the erection of a new 20-bed hospital at Whitewood which it is estimated would cost from $40,000 to $50,000. It will be called The Whitewood Memorial Hospital.

* * *

NORTH BATTLEFORD, SASK. The ladies of this city (now that their war activities are ended) have formed a hospital auxiliary. This group will not only render lay assistance to the hospital but will endeavour to further hospitalization in their community.

Manitoba

BRANDON, MAN. A travelling clinic unit being built in Winnipeg will be paid for with $10,000 which was presented to the Manitoba Sanatorium Board by the Brandon Club, Associated Canadian Travellers.

* * *

WINKLER, MAN. Progress made by Bethel Hospital was reviewed by Matron Derkson when its tenth anniversary was celebrated in July. The central section of the building, providing 15 beds, was erected in 1936 and the south wing, with 10 beds, was added in 1942. A north wing, to provide another 12 beds, two operating rooms, an x-ray room, offices and storage rooms, is now under construction. This wing of concrete, brick and tile, will cost approximately $40,000.

Ontario

BRACEBRIDGE, ONT. Plans have been been approved for an addition to the Bracebridge Memorial Hospital, which will include a self-contained maternity ward as well as an enlargement of the present kitchen and dining-room for employees.

* * *

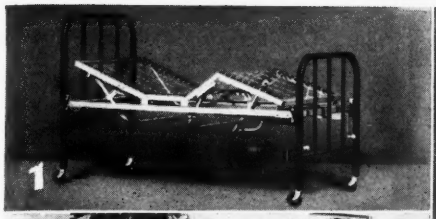
CAMPBELLFORD, ONT. Shriners, resplendent with Fezes and Arabian trousers, put on a show here recently in aid of the proposed $150,000 hospital. Mayor Ayrhart was present, complete with fractured foot, and "ten bucks" was charged for autographing the cast thereon.

* * *

KIRKLAND LAKE, ONT. Kirkland District Hospital will be handed over to the Township of Teck at the end of 1946 without any financial ties whatsoever. This institution, which has 144 beds, has been operated by the Canadian Red Cross Society for the past several years as an outpost hospital. The Red Cross stated that it can no longer operate the hospital because its bed capacity is beyond the size limit for their outposts. At the present time it serves practically all the towns between Kirkland Lake and the Quebec border.

* * *

LONDON, ONT. An industrial research project on hospitalization in Western Ontario, partly financed by the John McClary Memorial Fund for Research in industrial medicine, is being undertaken by the University of Western Ontario. Three graduate students will devote a year's study, under the direction of an advisory committee, to the investigation of hospitalization in this area in an attempt to determine to what extent hospitalization insurance held by industrial groups is a factor in the present shortage of hospital beds,



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Metal Craft Hospital Equipment is preferred by the majority. Outstanding quality of workmanship with constant improvement in design for convenience, safety and durability is assured in Metal Craft products.

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1. 7000B Series Bed with End Crank.
2. 7212 Streamlined Dresser with Wall Mirror.
3. 7073 Combination Bedside and Overbed Table.
4. 7037 Adjustable Overbed Table.
5. The Craftsman Operating Table.
6. 7193 Built In Instrument Cabinet.
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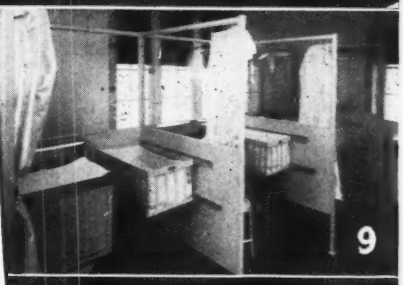
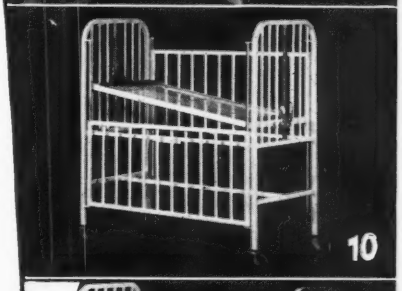
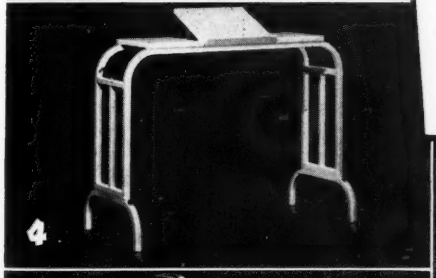
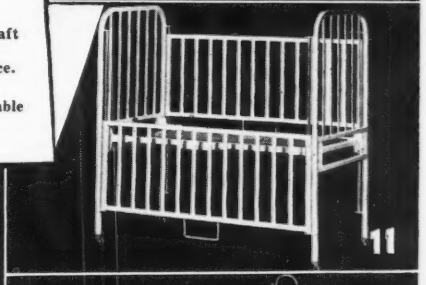
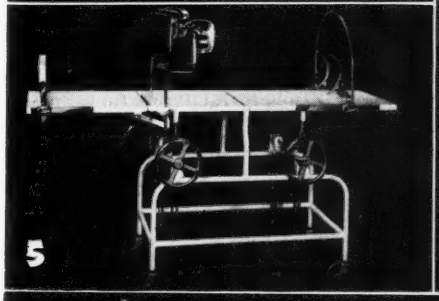
9. Nursery Cubicles . . . A Metal Craft Development.
10. 7017 Crib with safety locking device.
11. 7016 Crib.
12. Specially designed obstetrical table for the smaller hospital.

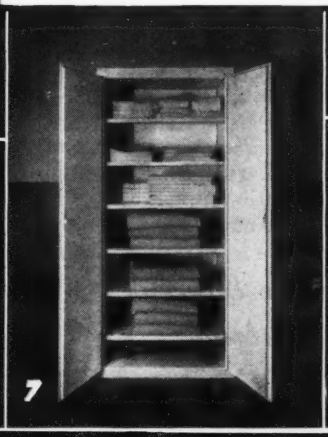


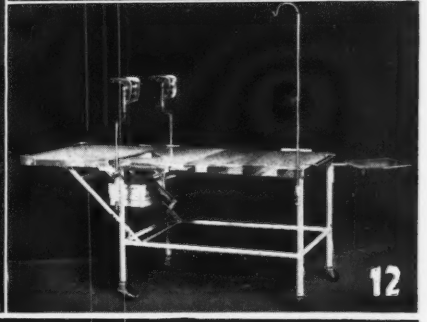












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Provincial Notes

(Concluded from page 66)

and to what extent it may be a factor in the future.

* * *

LONDON, ONT. A 200-bed addition to Victoria Hospital is proposed, and Dr. Crozier, the superintendent, states that 100 of these beds will be reserved for cancer sufferers.

* * *

TORONTO, ONT. Dr. W. E. Crysler has been appointed director of radiology at the Toronto Hospital for Sick Children. He served as a radiologist in the RCNVR during the war and recently has been with the Department of Radiology of Toronto General Hospital.

Quebec

CHANDLER, P.Q. A new hospital, under the direction of RR. SS. de la Providence de Montreal, will be erected shortly in the Gaspe Peninsula at Chandler.

* * *

THREE RIVERS, P.Q. The new Yamachiche Hospital, in charge of the Sisters of Providence, will be completed by September. This is a fifty-bed, fire-proof, brick building and has been constructed on the site of an earlier hospital which was burned down in 1923. The architect is M. Jean-Louis Caron of this city.

New Brunswick

BATHURST, N.B. Dr. G. E. Gauvin, formerly superintendent of Vallee Lourdes Sanitorium here has been appointed medical superintendent of the new tuberculosis hospital at St. Basile, N.B. Dr. Gauvin is a well known authority on tuberculosis and has had wide experience as an institutional physician.

* * *

MONCTON, N.B.—The department of health of the province of New Brunswick has purchased five buildings at No. 10 R.C.A.F. Release Centre at Moncton, which are to be used as a tuberculosis hospital.

SAINT JOHN, N.B. Because of the problem of providing accommodation, the flat-rate plan for maternity cases at Saint John General Hospital was suspended on July 1st, though arrangements made under that scheme earlier will be carried out. The finance committee is considering an adjustment of the ward rate for the residents of the city and the county.

* * *

SUSSEX, N.B. Miss Marguerite King, has been appointed dietitian of the former Sussex Military Hospital which has been taken over by the Department of Veterans Affairs. She comes to her new position after two and a half years at Jordan Memorial Sanitorium, River Glade.

* * *

WOODSTOCK, N.B. A resolution has been passed by Carleton County Council which proposes the construction of a new hospital at Woodstock. The institution which would also serve the town of Hartland and the municipality of Carleton would be constructed according to a joint agreement between the three and on an equitable basis.

Nova Scotia

SHEET HARBOUR, N.S. Work will start soon on a new 20-bed hospital at this village in Halifax County. It will be known as the Eastern Shore Memorial Hospital. The plans have been drawn by Leslie R. Fairn of Halifax and Wolfeville.

Prince Edward Island

SUMMERSIDE, P.E.I. The ladies of the Okto Club have pledged themselves to raise the sum of $2,000 toward the construction of the new Prince County Hospital. They netted a substantial amount through an auction of used furniture, especially since many fine antiques, clocks, lamps, spinning wheels, etc., were donated.

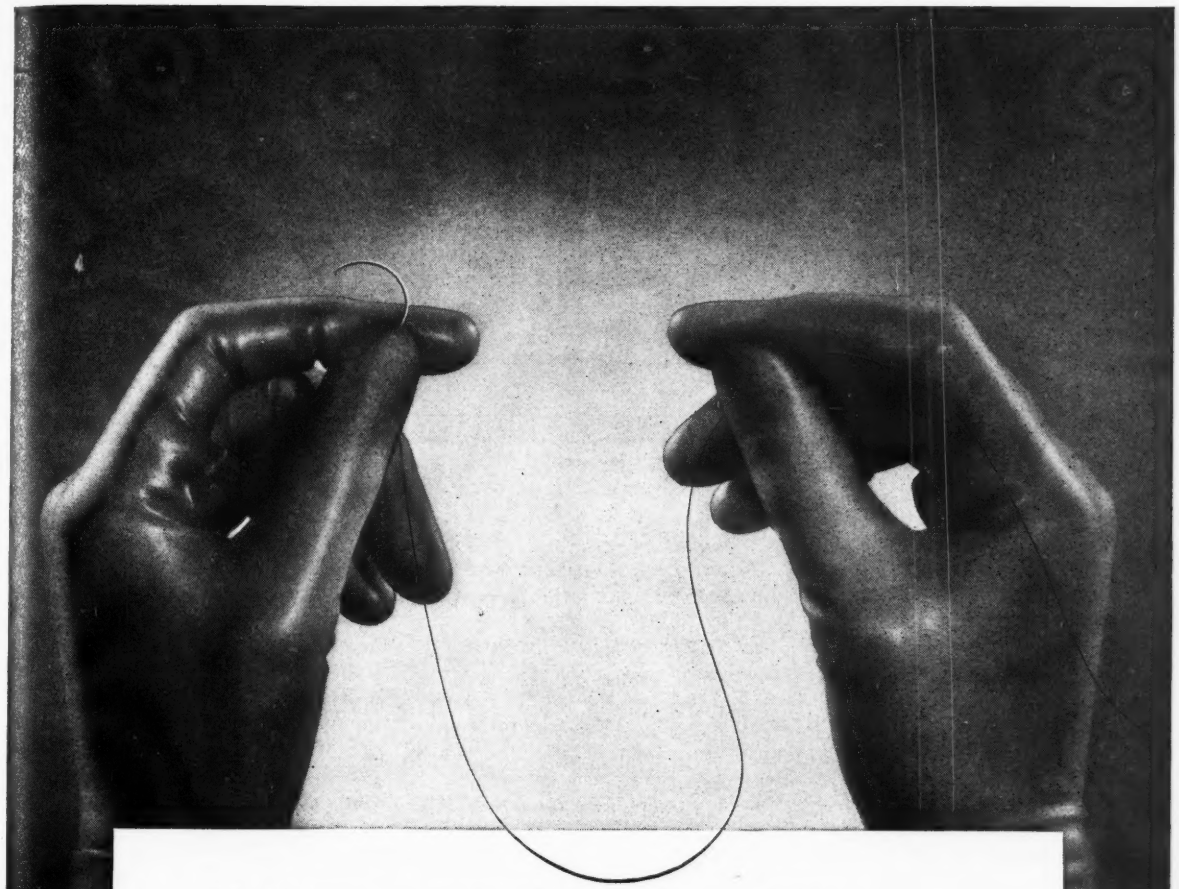
"Science and Religion"

The doctor will labour, in word and work, to destroy the false and foolish notion, widespread as any disease, that there is disagreement and open opposition between science and religion. He will show a world that needs the showing that a man of science is also a man of deep religious devotion. There is not, there never has been, there never can be a conflict between true science and true religion. It is strange that the harmful conviction of such a conflict is so general in minds that ought to know better. Chesterton gives us an accurate account of the origin of this sad conviction, although he does not pause upon the point of its destructive endurance. He says that "19th century scientists were just as ready to jump to the conclusion that any guess about nature was an obvious fact, as were 17th century sectarians to jump to the conclusion that any guess about Scripture was the obvious explanation. Thus, private theories about what the Bible ought to mean, and premature theories about what the world ought to mean, have met in a loud and widely advertised controversy, especially in the Victorian time; and *this clumsy collision of two very impatient forms of ignorance* was known as the quarrel of Science and Religion". To the dispelling of this evil ignorance, the Church devotes suitable effort, and she enlists the willing assistance of her men of science, notable among whom are her men of medical science.

—The Most Reverend Michael J. Ready, D.D., Bishop of Columbus, in "The Linacre Quarterly".

In the attainment of a modicum of wisdom, together with a bit of satisfaction in attaining it, years of well directed effort are required. An ancient philosopher said: "Man earns his bread by the sweat of his brow." It is well that this is everlastingly true despite some recent efforts to alter the premise. Man earns his bread by the sweat of his brow and retires to slumber deeply, weary but happy in the knowledge of a decent day's work. Do not be afraid to work. Constructive effort is one of God's finest gifts to man.

—Charles S. Kennedy, M.D., Journal of the American Medical Colleges, May, 1946.



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Penicillin in Treatment Of Syphilis

In view of the current wave of enthusiasm regarding the use of penicillin in the treatment of syphilis, an editorial appearing in the May 1946 issue of *The Journal of Venereal Disease Information* would appear to be the most appropriately timed. To emphasize the present status of this therapy, excerpts from this editorial are presented.

"It cannot be repeated too often nor too emphatically that penicillin therapy of syphilis is still an experimental procedure. This is true because of the prolonged course of the disease and its tendency to recur after periods of latency, and applies with equal force to any new treatment, drug or procedure. Organized, coordinated methods of study and observation enlisting the help of clinicians, laboratories, and institutions undoubtedly speed up evaluation, but there is still a minimum period of five years of continuous observation on several thousands of patients which is absolutely necessary before final conclusions can be drawn."

The editorial continues by enlarging upon the incomplete state of our knowledge concerning penicillin therapy, discussing the recent discovery that some penicillin seemed to have become less effective in the treatment of syphilis. Scattered reports to this effect by various clinicians and other agencies interested in the treatment aspects of syphilis control, confirmed in experimental animals by responsible investigators, during February 1946, led to the conclusion that the situation should be promptly appraised.

Accordingly, a meeting was called during March at which all interested agencies were present. From this meeting it developed that the "K" fraction of penicillin predominated in the less effective product whereas the "G" fraction had predominated in the earlier products which have given much better results. It was agreed by manufacturers that an effort would be made to produce penicillin in which the more effective "G" fraction predominates. In addition, greater attention will be given, in research, to determining the effectiveness of the various fractions of pencillion.

The early recognition by clinicians that penicillin therapy for gonorrhoea required continued observation, to guard against the possibility that the subcurative penicillin dosage might have suppressed or aborted a concomitantly acquired syphilis infection, leads to the possibility that something of the same situation applies to syphilis patients treated with penicillin in which the aberrant "K" fraction predominated —they may have received what was, in effect, a subcurative dosage.

This observation should remind physicians of the importance of explaining to every patient, regardless of the drug and treatment schedule used, the necessity for completing treatment and for periodic examinations. With any new type of therapy this becomes an obligation on the part of the physician to the patient, to the public and to the advancement of medical science.

(Concluded on page 72)

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V.D. Briefs

(Concluded from page 70)

It was noted that the likelihood of intensive follow-up on most of the patients treated for syphilis with penicillin is optimistic since many who are properly instructed on the importance of this phase of their treatment will report voluntarily and consistently for their diagnostis check-up.

Placing emphasis upon an important feature, the editorial continues:

"We reiterate that much remains to be learned about penicillin, its composition and mode of action, and its ultimate place in the treatment of syphilis. Despite the most encouraging clinical evidence of its very real value in sterilizing early lesions, and its great apparent usefulness against syphilis in pregnancy, and central nervous system syphilis, it cannot yet be said that penicillin is more effective than arsenical - bismuth therapy from the standpoint of producing 'cures'. Several years of observation on several thousands of patients treated under the various schedules will be necessary before a dependable evaluation can be made."

In conclusion it is noted that the experience with penicillin species "K" emphasizes the interdependence of industry, laboratories, treatment sources, and public and private agencies in promoting the control of syphilis.

American College of Surgeons Changes to Cleveland

Owing to the shortage of hotel accommodation as a result of the holding of the United Nations Assembly in New York in Septemberr, the American College of Surgeons has decided to change its Clinical Congress which was to have been held at the Waldorf-Astoria, September 9 to 13, to Cleveland, December 16 to 20. The United Nations meeting was announced 90 days after arrangements had been completed to hold the Clinical Congress in New York, but as the United Nations meeting may run between 6,000 to 8,000 attendance, it will be impossible for the Congress, which at least 5,000 people want to attend, to be held during the same period.

Headquarters will be at the Cleveland Public Auditorium. This will be the first Annual meeting of the College since November, 1941. The opening session will be the Hospital Standardization Conference on Monday morning, December 16, at 10 o'clock. Talks will be given by medical and hospital authorities on advances in medicine and surgery as they affect the postwar hospital. The hospital conferences will continue each morning and afternoon through Thursday, with evening sessions on Tuesday and Wednesday.

Panel discussions will take place on general surgery, opthalmology and otorhinolaryngology. There will be forums and sumposiums on a number of timely topics.

The concluding event of the Congress will be the Convocation on Friday night at which fellowships will be conferred upon candidates.

Dr. W. Edward Gallie of Toronto is President, and Dr. Irvin Abell of Louisville is Chairman of the Board of Regents of the American College of Surgeons. Drs. Bowman C. Crowell and Malcolm T. MacEachern of Chicago are Associate Directors.

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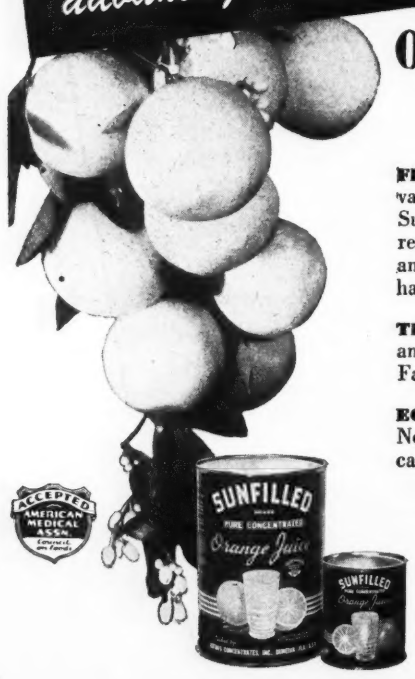

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Gerhard Hartman goes to University of Iowa

Mr. Gerhard Hartman, who became widely known as executive secretary of the American College of Hospital Administrators, assumes his duties as superintendent of the University of Iowa Hospital at Iowa City in July. He succeeds Mr. Robert E. Neff, a former president of the American Hospital Association and of the A.C.H.A. who resigned recently to take a similar position in Indianapolis, Indiana.

The new appointee will also be professor of hospital administration at the University and in this capacity will head a professional training program.

Mr. Hartman has been director of the Newton-Wellesley Hospital in Massachusetts. He holds two degrees from the University of Buffalo and a Ph.D. in hospital administration from the University of Chicago. He has written extensively for hospital journals and is co-author of the well-known book "The Hospital in Modern Society". While in Chicago he served on the faculty of hospital administration at the University of Chicago.

Group Practice

(Concluded from page 54)

is easily and directly obtainable. When the offices of the group are an integral part of a hospital, economies can be effected through the elimination of duplicate equipment and technical personnel.

It may be argued that placing the doctor's office in the hospital works an inconvenience on the patient by requiring him to make longer trips for office calls. This would be true if hospitals were located in remote sections of their communities. However, they are usually situated conveniently so that they are accessible to the majority of the residents of an area. The disadvantage to individual patients is more than offset because such an arrangement saves time for the patient that would otherwise be spent in going from one physician's office to another. It also conserves the time of the physician and enables him to care for more patients.

The conservation of professional time should not only result in placing the doctor's service at the disposal of more people but also in reducing the cost of medical care. The various diagnostic facilities can be utilized to greater extent with comparatively little additional expense. Increased volume of use should result in more effective use of the time of technical personnel and equipment in a reduced per patient cost.

Group practice tends to improve the quality of medical care. Individual and collective experiences form the basis for group growth in professional knowledge and skill. The proficiency of the group increases as individuals limit themselves to the kind of case they are most capable of handling. Also, through organization group members can arrange attendance at meetings and take advantage of educational opportunities in medical centres away from the community. Through such continuing education of the members of the group recent advances in medical science would be made more quickly available for application by the group.

Experience—the master of medicine.—*Thomas Sydenham.*

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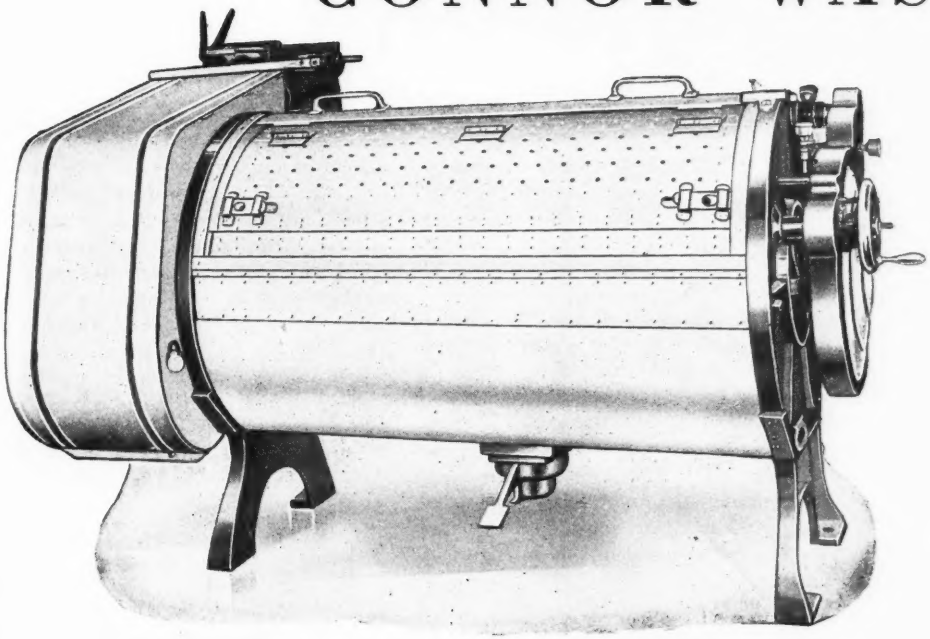

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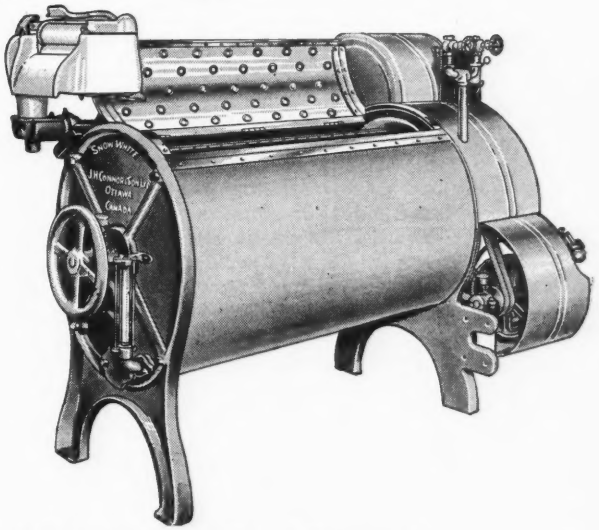

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Research and Longevity

"The days of our years," says the psalmist, "are as of three-score years and ten." Though medicine has doubled the average length of life in fifty years, seventy continues to be a ripe old age and those who claim to reach one hundred are usually poor at arithmetic or have convenient memories. One of the next major problems of the doctors is to add fifty or a hundred years to the accepted three score and ten. Most of us were born a bit too early to participate in these prospective benefits. It has well been said that a man is as old as his arteries. To alter man's heredity of sixteen or sixty million years and to supply him with arteries which will endure indefinitely or to preserve those arteries with which man is now endowed from attacks from worry, disease and the various other poisons by which man is beset, is the opportunity and the duty of future generations of doctors. Greater opportunities, together with the tools at hand, by which man's destiny may be fulfilled have never been available to the profession.

In order that many of these much-to-be-desired ends may here be attained, a somewhat different approach to the problem—man—must be made. First, there must be an improved laboratory in which the genus *Homo sapiens* together with his difficulties, mental and physical, may be appraised, analyzed, diagnosed and treated. Such splendid laboratories have sprung up over the wide stretches of this land that today the universities, hospitals and research institutions in our country are unexcelled and seldom equalled anywhere. . . .

No one can now be an authority on all phases of disease, or scarcely even one, but when great universities collaborate on a problem so that the knowledge of the internist and the surgeon, the bacteriologist and the pathologist, the biochemist, physicist, physiologist and the psychiatrist, together with a score of other experts in various fields,—when all these can be turned loose on one problem, something good for the welfare of mankind is bound to eventuate. This to me seems to be one of the main goals of the univerity. Each man must have his own individual problem but in many instances it should be the aim of university accomplishment to turn all of the available big guns on one problem and annihilate it.

Charles S. Kennedy, M.D., Journal of the American Medical Colleges, May, 1946.

Hospital Service

We are fully sympathetic with the aims of those who would like to have more medical and hospital service available to more people. That is also one of our aims. However, we do not believe it can be wisely and effectively accomplished in one bold stroke. Rather we believe it requires an orderly, intelligent program which will be more closely integrated to the needs of our people. It takes eight years to train a physician. Hospitals can be built more rapidly, but it also takes time to develop the highly trained personnel necessary to provide our citizens with the high quality of hospital service which they have come to expect and desire when they are sick.

—John H. Hayes. President-Elect, American Hospital Association.

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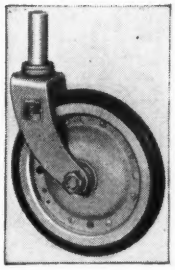

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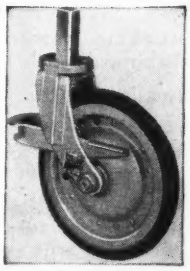

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—From "Heating in Hospitals" by H. A. Sandford, Consulting Engineer, published in THE HOSPITAL, February 1946.

What Is Good Nursing?

Good nursing is easier to recognize than to describe, possibly because it represents a service into which enters so wide a variety of abilities and characteristics, and possibly because there can be no set pattern, since the illness and individual differences of patients will affect the form it takes. But certain it is, that good nursing is a compound into which enter the intelligent application of principles, the practice of good procedure technique and the caring for the mental and emotional, as well as the physical, needs of the patient. For no matter how well a department is organized or how well qualified the personnel, the acid test of the nursing service in a hospital is the quality of the nursing care that patients receive and the sense of peace and security they feel while they are in the hospital. Mary Roberts, Editor of *The American Journal of Nursing,* has described quality nursing thus: "Creating a pool of contentment all around the patient." What greater satisfaction could the nurse desire!

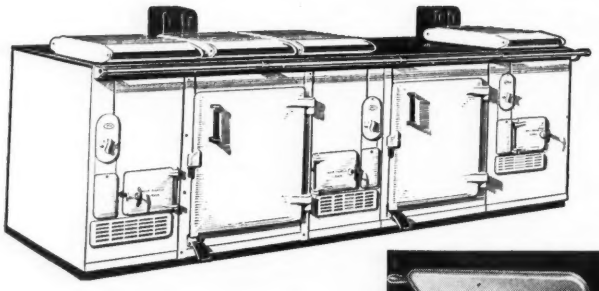
—Gertrude Hall, Reg. N.

Pasteurization Urged

Pasteurization of milk should be generalized. Raw milk and its products still remain the cause of too many infections—tuberculosis, typhoid fever, undulant fever, and a considerable amount of infant mortality. The results obtained where pasteurization of milk has been enforced are proof of its value.

—A. Groulx, M.D., M.P.H., Montreal.

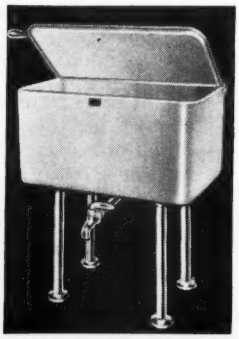
SIX REASONS WHY YOU SHOULD BUY AN AGA COOKER



- Reduces meat shrinkage to a minimum.
- Increased economy—a new low in fuel costs.
- Always ready for instant use.
- All cooking temperatures automatically controlled.
- Unusually even heat in the ovens.
- Aga cooking gives food a new flavour and richness.

AGA CAST ALUMINUM COOKWARE

Aga Cast Aluminum Cookware is in use in large establishments all over the country. Combining many features, such as lifetime wear, low cost and economical operation, our cast aluminum units are designed for quality and quantity cooking. Heavy flat bottom prevents warping and distortion. These units are now available at the lowest cost in 20 years. For further information regarding equipment for your kitchens, write or call at our Toronto or Montreal showrooms.

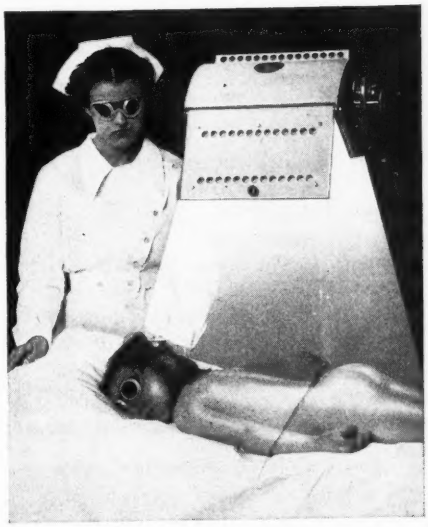


For large quantity roasting, stewing, or boiling, this steam roaster is indispensable. Complete with strainer, draw-off faucet and connections, the roaster can also be filled with baskets and grids, making it a vegetable steamer as well.

AGA COOKER AGA HEAT (CANADA) LIMITED
2187 BLOOR STREET W., TORONTO
1075 BEAVER HALL HILL, MONTREAL

For Best Results in Ultraviolet Therapy use the

HANOVIA LUXOR ULTRAVIOLET ALPINE LAMP



Featuring a Wide Range of Clinical Usefulness

American Medical Ass'n ACCEPTED Council on Physical Therapy

The MODERN, EFFICIENT, SELF-LIGHTING Hanovia Luxor Alpine Lamp delivers the complete mercury spectrum in the invisible ultraviolet. This Lamp is designed to give a uniform irradiation of one side of the body at one exposure, and produces the kind of results that please both the patient and the doctor.

Its wide usage includes beneficial radiation in skin diseases, surgery, rickets, infantile tetany, erysipelas, tuberculosis of the bone, secondary enemia, etc.

Further interesting and technical information will be promptly sent upon request.

HANOVIA

CHEMICAL & MFG. CO.

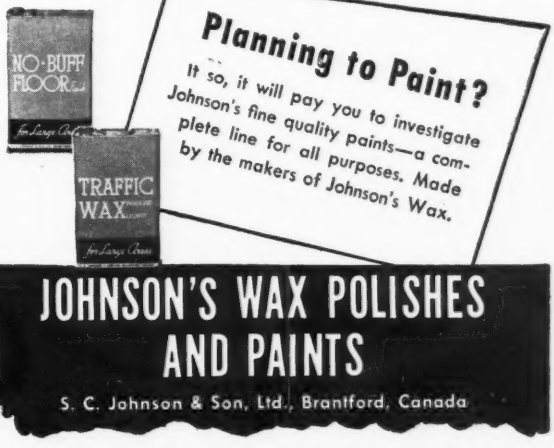
Dept. CH-39 **Newark 5, N.J., U.S.A.**

World's largest manufacturers of therapeutical equipment for the Medical Profession.

YOUR BUILDING is as beautiful AS ITS FLOORS!

Handsomely polished floors set off the beauty of any interior. Floor beauty . . . *and* protection is yours for the *waxing* . . . with Johnson's heavy-duty wax polishes. Use them to have more beautiful floors . . . to prolong their life . . . to make them more sanitary as well as easier to clean. Two types:

1. ***Johnson's TRAFFIC WAX.*** In paste and liquid form. A genuine buffing wax for heavy traffic areas. Famous for the tough wax protection and the wax polished beauty it imparts to wood and linoleum floors . . . also furniture, woodwork.
2. ***Johnson's NO-BUFF Floor Finish*** (green label). A wonderful floor protector and beautifier for large floor areas. No rubbing or buffing . . . shines as it dries . . . just apply and let dry. Use Johnson's NO-BUFF on wood, linoleum, rubber, asphalt tile, terrazzo, etc. *Brown Label* No-Buff has an extra water-resistant property.



JOHNSON'S WAX POLISHES AND PAINTS

S. C. Johnson & Son, Ltd., Brantford, Canada

A.H.A. to Hold First Post-War Meeting

Hospital staff problems and the final report of the Commission on Hospital Care will feature the 48th Annual Convention of the American Hospital Association, to be held in Philadelphia from September 30 to October 3.

The Report will be presented by the chairman, Thomas S. Gates, and Dr. A. C. Bachmeyer will summarize the conclusions and recommendations of the Commission. Representatives of labour, industry, agriculture and other interested groups will address the session, and the whole report will be gone into thoroughly, with two general sessions being devoted to it. The two remaining general sessions will be concerned with staffing the hospital.

Highlighting the sectional meetings will be that on the American Hospital Retirement Plan, to be introduced by Mr. Homer Wickenden. All sectional meetings have been arranged to present practical discussion of current administrative problems confronting hospitals.

Of special interest to Canadians will be the International Dinner on Tuesday evening to honour representatives of other countries attending the convention. General sessions and sectional meetings will be in the Philadelphia Convention Hall and headquarters of the Association will be at the Bellevue-Stratford Hotel.

Change of Address

Dr. John C. Mackenzie, Hospital Consultant, has announced that offices have been opened at 1415 St. Mark Street, Montreal, 25.

Needed—A Public Conscience

Few people can be trusted with much money and leisure. If larger incomes and shorter hours of work are demanded, then at the same time we must all learn the right use of money and leisure.

If happiness demands for each of us three meals a day, a comfortable home, a piano, a radio, a cycle or motor car, physical and mental recreation and an annual holiday, then everyone must definitely earn and deserve these amenities by giving a greater quality and quantity of service than we have ever given before. One does not need to have a knowledge of higher economics to realize the common justice and the relentless necessity for such increased production and service.

Each of us has a grave responsibility in these critical days and unless there is an awakening of the public conscience and a definite acceptance of a high moral purpose in our corporate endeavours, I see no hope of a return to 1938 standards of living.

We achieve the best quality of service in work that we enjoy. The best work done in the world has seldom been done merely for monetary rewards. Let it be generally accepted, that our everyday job is a service for the well-being and happiness of the entire community, including our own domestic circle.

Let us emphasize the thrill of achievement, the pride of making things, the joy of creation and construction.

The feeling that one's labours are really appreciated and useful, is a more effective stimulus and satisfying reward to the average person, than scheduled rates of pay.

—From an address by Sydney Lamb to the Canterbury Rotary Club.

AT HOME OR AWAY SPOT TESTS SIMPLIFY URINALYSIS

NO TEST TUBES • NO MEASURING • NO BOILING

Diabetics welcome "Spot Tests", (ready to use dry reagents), because of the ease and simplicity in using. No test tubes, no boiling, no measuring; just a little powder, a little urine—color reaction occurs at once if sugar or acetone is present.

Galatest FOR DETECTION OF SUGAR IN THE URINE

Acetone Test (DENCO) FOR DETECTION OF ACETONE IN THE URINE

SAME SIMPLE TECHNIQUE FOR BOTH

1. A LITTLE POWDER  2. A LITTLE URINE

COLOR REACTION IMMEDIATELY

Accepted for advertising in the Journal of the A.M.A.

Write for descriptive literature

A carrying case containing one vial of Acetone Test (Denco) and one vial of Galatest is now available. This is very convenient for the medical bag or for the diabetic patient. The case also contains a medicine dropper and a Galatest color chart. This handy kit or refills of Acetone Test (Denco) and Galatest are obtainable at all prescription pharmacies and surgical supply houses

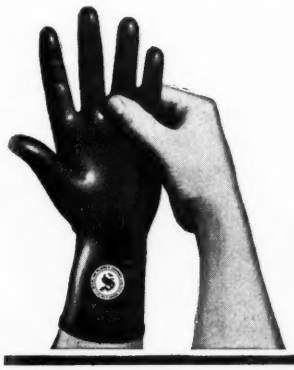
THE DENVER CHEMICAL MANUFACTURING COMPANY
153 Lagauchetiere Street, W., Montreal

STERLING GLOVES

Featuring

The Reinforcing Band at the Wrist

Specialists in Surgeons' Gloves for over 33 Years.



STERLING RUBBER CO.
— LIMITED —
GUELPH - ONTARIO

The STERLING trade-mark on Rubber Goods guarantees all that the name implies.

TO TEMPT THE APPETITE OF...

CONVALESCENTS

SUGGEST RENNET-CUSTARDS

Often it is a problem to include foods in the diet which appeal to a convalescent appetite, and at the same time are easily digested and nourishing. Rennet-custards made with the 6 flavors of "JUNKET" RENNET POWDER provide dozens of delightful variations, and often are the means of adding important nourishment.

FREE ... Ask on your letterhead for our new book: "Milk and Milk Food in Diet Planning."

"JUNKET" RENNET POWDER
6 Flavors—Packed in institutional and household sizes
"JUNKET" RENNET TABLETS
Not sweetened or flavored

"THE 'JUNKET' FOLKS"
CHR. HANSEN'S LABORATORY
Toronto, Ont.

"JUNKET"
TRADE-MARK
RENNET POWDER

WE'RE LOOKING FOR TROUBLE

It's not that we're pugnacious, but we like trouble because looking for it has found us a lot of friends. We mean sanitation trouble, of course . . . like the removing of uncertainties from the supplying of cleansing compounds.

McKemco Compounds are "custom-built" to meet peculiar problems and water conditions in your hospital. An intensive study and analyses of water in a long list of populated districts have given us an understanding of problems to which your hospital is subject. Our expert chemists have evolved formulas which combat these conditions effectively.

We're looking for trouble . . . your trouble . . . consult us freely . . . we will be pleased to give you every assistance.

DISH WASHING COMPOUND

The hardness of the water in your locality should determine the type of dish washing compound you use. We custom-build our cleansers to suit your own local conditions—not only for efficient cleansing but ALSO to prevent the formation of scale on your machine.

SPECIALIZED LAUNDRY COMPOUNDS

Here again we are prepared to meet prevailing water conditions to assure high detergency value and low tensile strength loss to the fabrics.

McKEMCO DETERGENT

For cleaning tile, terrazo, basins, bathtubs, sinks, etc. Maximum cleansing properties with minimum abrasive actions.

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McKEMCO Products

Telephone Randolph 8383

Made in Canada

McKAGUE CHEMICAL COMPANY
MANUFACTURERS AND DISTRIBUTORS OF SPECIALIZED CLEANERS AND ALKALIES
1119A YONGE ST. TORONTO, CANADA

Colour Conditioning

(Concluded from page 62)

that if each of these colours can become identified in the minds of workmen with its purpose then the colours will become signals for safety at all times. The more generally they are used, the more widespread will be their effectiveness. The colours and their uses are as follows:

High Visibility Yellow — to indicate striking, stumbling or tripping hazards.

Alert Orange—To mark parts of machines that might cut, crush or otherwise injure a workman.

Safety Green—To identify first aid equipment, dispensaries and the location of safety devices.

Fire Protection Red—To point out fire protection equipment. Red should not be used in relation to first aid, or on waste pails or any equipment or surface that is not connected with the extinguishing of fire.

Precaution Blue—To warn workers against the use of equipment under repair or machinery that should not be put into operation.

Traffic White — To mark aisles, storage places and waste receivers.

Piping Identification

Closely associated with the Safety Colour Code and somewhat similar to it in its recommendations is the Piping Identification System. Here the functional use of colour facilitates identification of piping and valve systems so that at a glance the worker may know if it is safe for him to work on any pipe that requires attention. This is especially true in case of emergency. The colours may be applied over the whole pipe or in bands or employed to write a legend on the under side of the pipe.

The four major colours used are:

Yellow — for piping containing dangerous materials.

Green—for piping containing safe materials.

Blue—for piping containing protective materials.

Purple — for piping containing extra valuable materials.

Additional colours such as grey, aluminum, brown, white and black may be used for purposes other than those listed under the four major headings.

Coming Conventions

September 16-26—Institute on Administration, A.C.H.A., Chicago.

September 28-30—American College of Hospital Administrators, Philadelphia.

September 30-October 4—American Hospital Association, Philadelphia.

October 21-24—Ontario Hospital Association, Royal York Hotel, Toronto.

October 21-23—International College of Surgeons, Detroit.

October 28-November 2—Institute on Administration and Convention, Manitoba Hospital Association, Royal Alexandra Hotel, Winnipeg.

November 5-6—Saskatchewan Hospital Association, Saskatoon.

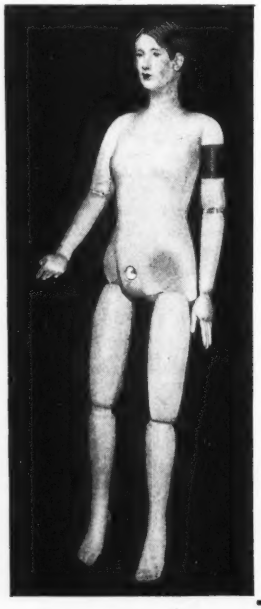
November 6-8—Associated Hospitals of Alberta, Palliser Hotel, Calgary.

November 12-15—British Columbia Hospitals Association, Vancouver.

December 16-20—A.C.S. Clinical Congress, Cleveland.

New Chase Dolls for the New Semester

CHECK the condition of the CHASE DOLLS you have on hand. . . . Order the additional ones you need.



ADULT FEMALE HOSPITAL DOLLS

MODEL A without internal reservoir ..... **Each $75.00**
MODEL N new improved doll offering facilities for catheterization, bladder irrigation, vaginal douching, colonic irrigation, administration of enemas, hypodermic injections and nasal and otic douching ..... **Each $150.00**
Also available in MALE form ..... **Each $150.00**

INFANT AND CHILD SIZE DOLLS

	Size	Equipped with nasal and otic reservoirs	Also have abdominal reservoir
NEWBORN BABY	20"	$12.00	
2-MONTHS BABY	22"	15.00	$20.00
4-MONTHS BABY	24"	17.50	22.50
1-YEAR BABY	30"	20.00	25.00
4-YEAR CHILD	42"	30.00	

Prices in U.S.A. Canadian prices slightly higher.

Order them now while the matter is before you!

CLAY-ADAMS CO INC.
44 EAST 23rd STREET, NEW YORK, N. Y.

Announcing!

THE NEW STANDARD

PATIENTS-PHONE SYSTEM

This newest unit in our line of hospital signalling systems is now in production, and is ready for prompt delivery at a moderate price.

Here is a voice communicating system between patient and nurse. Used in conjunction with our regular nurses call system, it will save countless steps and time because it permits the patient to tell the nurse of the need before a trip to the room is made. Write for full information today. 35

THE STANDARD ELECTRIC TIME CO.
OF CANADA LIMITED
MONTREAL 3, QUE.

THIS RAPID TUMBLER DRYER

Is Needed in Every Hospital Laundry

Rapid Loading—Rapid Drying—It Speeds up the laundry work — No waiting for clothes to dry.

No. 2 Rapid Tumbler Dryer — capacity 26 pounds of dry clothes in 30 to 45 minutes. Cylinder 36" diameter, 24" deep. Supplied with steam, electric or gas heater.

No. 3 Rapid Tumbler Dryer — capacity 32 pounds. Cylinder 36" x 30". Equipped with gas or steam heater only.

No. 3 costs only $438.00
No. 2 costs only $400.00
(less sales tax to hospitals on Govt. list).

Write for catalogue and price list of Complete Laundry Equipment.

J. H. CONNOR & SON LIMITED
10 LLOYD STREET - - OTTAWA, ONTARIO
WINNIPEG 242 Princess St. MONTREAL 423 Rachel St. E.

water-mix DDT insecticide

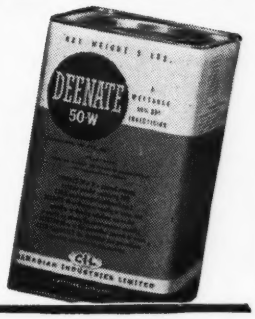
DEENATE 50-W, the C-I-L *water-mix* DDT insecticide, rids premises of disease-bearing insects — flies, cockroaches, many others. A powder — no inflammable oil, no fire risk. Just mix with water.

low-priced ... easy to use

DEENATE 50-W is economical to buy and use. One pound makes enough spray to cover up to 1600 square feet of surface. May also be applied with a paint brush or dusted in cracks or crevices in powder form as received.

DEENATE 50-W

DEENATE 50-W leaves a deposit which kills insects weeks after spraying. It's clean, easy to handle, no unpleasant odour. (In some circumstances, the slight white residue left by **DEENATE 50-W** may be a disadvantage). In handy 1-lb. and 5-lb. cans.



CANADIAN INDUSTRIES LIMITED
AGRICULTURAL CHEMICALS DIVISION

Better Indian Health Services Planned

A new health program for Canadian Indians has been announced by the Honourable Brooke Claxton, Minister of Health for the Dominion, and the plans were discussed by Dr. P. E. Moore of Ottawa while on a recent tour of the western provinces.

A new hospital at Norway House and the enlargement of the Clear Water Lake Hospital north of The Pas are the main improvements to be made in Manitoba. It is proposed to build a 50-bed extension to the Indian hospital at Fort Qu'Appelle, Saskatchewan, and to replace the nurses' residence which was destroyed by fire.

Five regional health superintendents for Indians throughout the north will be appointed, to work closely with the Indian agents. An air ambulance service to bring out seriously ill patients will be established by arrangements with the R.C.A.F. or department of transport planes.

Dr. G. J. Wherrett, executive secretary of the Canadian Tuberculosis Association, has indicated that tuberculosis rates are steadily decreasing, partly as a result of the mass survey program and that his Association is greatly encouraged by the progress made by the Indian Affairs branch in controlling the disease. Dr. R. S. C. Corrigan of Norway House is making a cruise to far northern waters this summer to give medical attention to Indians and Eskimos.

REGISTERED PHYSIOTHERAPIST WANTED

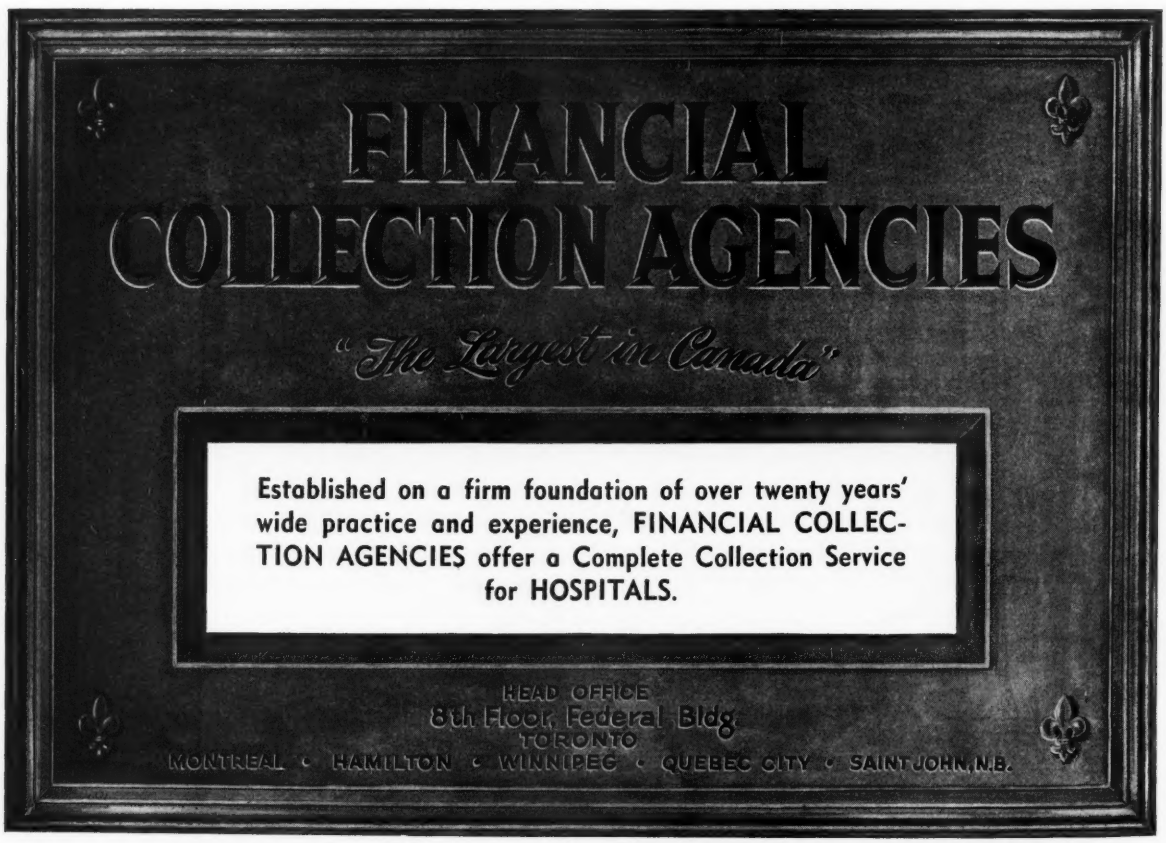
For 50-bed Children's Orthopaedic Hospital with O.P. Department. Good equipment. Broad field of service. Applicants state salary expected. Junior Red Cross Hospital, Calgary, Alberta.

VACANCIES FOR STAFF DIETITIANS

The University Hospital, Edmonton, Alberta, has vacancies for staff Dietitians. Excellent opportunities in both administrative and therapeutic fields. Details will be sent upon request. Applications to be made to the Director of Dietetics, University Hospital.

SUPERINTENDENT WANTED

500-bed hospital, Victoria, B.C., invites applications from medical men for position of Superintendent. Administrative education, experience required, salary open. Address, full particulars marked "Executive" to Secretary, Royal Jubilee Hospital, Victoria, B.C., before September 30th.



Safe FROM INK OR IODINE!

Strongly colored liquids like ink, iodine or coffee cannot penetrate the non-porous surface of a Formica decorative sheet. They dry on the surface and are easily wiped off with a damp cloth. Lighted cigarettes burn to the very end on a cigarette proof Formica surface without leaving a mark that is not easily removable.

Therefore, a Formica surface is capable of many years of service without maintenance attention. It does not have to be taken out of service. The cost of painting and finishing just doesn't happen. And it is so quickly and easily cleaned with a damp cloth—or with solvents if that is necessary—there is a substantial saving in cleaning labor. These savings have been estimated at $100 a square foot in 20 years. Worth while, isn't it?

FORMICA

Arnold Banfield & Co., Oakville, Ontario, Toronto, Montreal and Vancouver

Maybe You Won't Have to Repaint Those Walls!

Before you decide to repaint your walls or woodwork, try cleaning them with Oakite Renovator. Chances are, painting may be deferred.

Merely wipe down surfaces with cloth moistened in recommended solution of Oakite Renovator. Without rinsing, polish surfaces with clean, dry cloth. You'll be amazed to see how thoroughly Oakite Renovator removes paint-disfiguring dirt to give surfaces a high lustrous gloss. And you'll like the high dilution ratio that spells economy. Try it today!

Ask your nearby Oakite Technical Service Representative for on-the-spot advisory help. Or, write NOW for further details. Both services FREE . . . naturally!

OAKITE PRODUCTS OF CANADA, LTD.

J. J. FITZSIMMONS.....65 Front St. E., Toronto, Ont. Tel. Elgin 7655
G. W. EMPSON .....1 Van Horne Ave., Montreal, Que. Tel. Crescent 1143
T. W. DAY .....1 Van Horne Ave., Montreal, Que. Tel. Crescent 1143
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VANCOUVER OFFICE ..... 550 Beatty St., Tel. Pacific 9311

OAKITE *Specialized* CLEANING

MATERIALS · METHODS · SERVICE · FOR EVERY CLEANING REQUIREMENT

Warmth Softness Durability COMBINED IN

Ayers PURE WOOL

Ayers
PURE WOOL
BLANKETS
OVERTHROWS
RUGS
"Canada's Own"

AYERS LIMITED
LACHUTE MILLS, Que.
Established 1870

B14

Confidence!

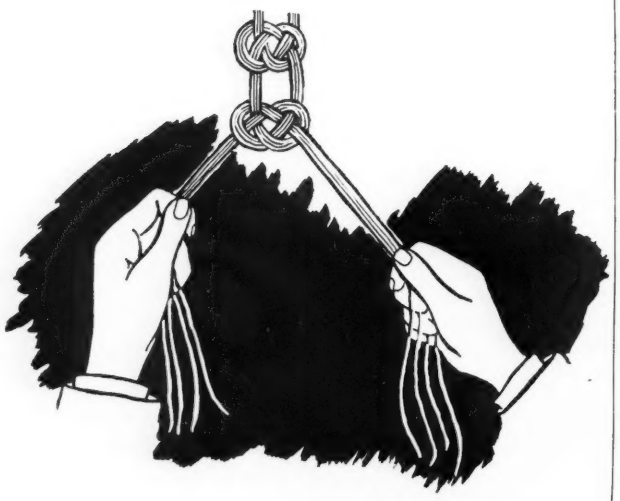
ETHER

MALLINCKRODT CHEMICAL WORKS LIMITED

MONTREAL - TORONTO

PLANT AT LASALLE, QUE.

Tools for the THERAPIST



Here are excellent new materials for therapists who aim to develop manual dexterity as an aid to convalescence—

FELLOLETHER

—an alternate for leather—is a plastic-impregnated fabric, is tooiable without wetting. FELLOLETHER can be cut, shaped, stamped—worked in nearly every way . . . sheets 48″ x 36″. Your choice of five colors: brown, black, blue, green, red.

FELLOLACE

—the pliable plastic as flexible and workable as leather. An ideal complement for leather and FELLOLETHER projects . . . use it alone too, for braiding and knotting . . . lacing moccasins . . . it's washable—won't chip or crack . . . black, brown, tan, red, white, blue, yellow, green, orange, in 100 yard tubes.

These are only two of FELLOWCRAFTERS hundreds of craft supplies and manuals. Send for FELLOWCRAFTERS Fourteenth Catalog for information on other materials. It's Free.

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Fellowcrafters INC. 130 CLARENDON ST. BOSTON 16, MASS.

Index of Advertisers

AUGUST, 1946

Small, Medium
and Large

Priced from $30.00
per Doz. and up.

Washable

BATHROBES, WRAPPERS, DRESSING GOWNS

for Patients

Made from assorted patterns of high quality washable eiderdowns and doe skins cut full and roomy. Full shrinkage allowance. All materials are subject to prior sale.

CORBETT-COWLEY LIMITED
C.C SERVICE APPAREL

CORBETT-COWLEY

Limited

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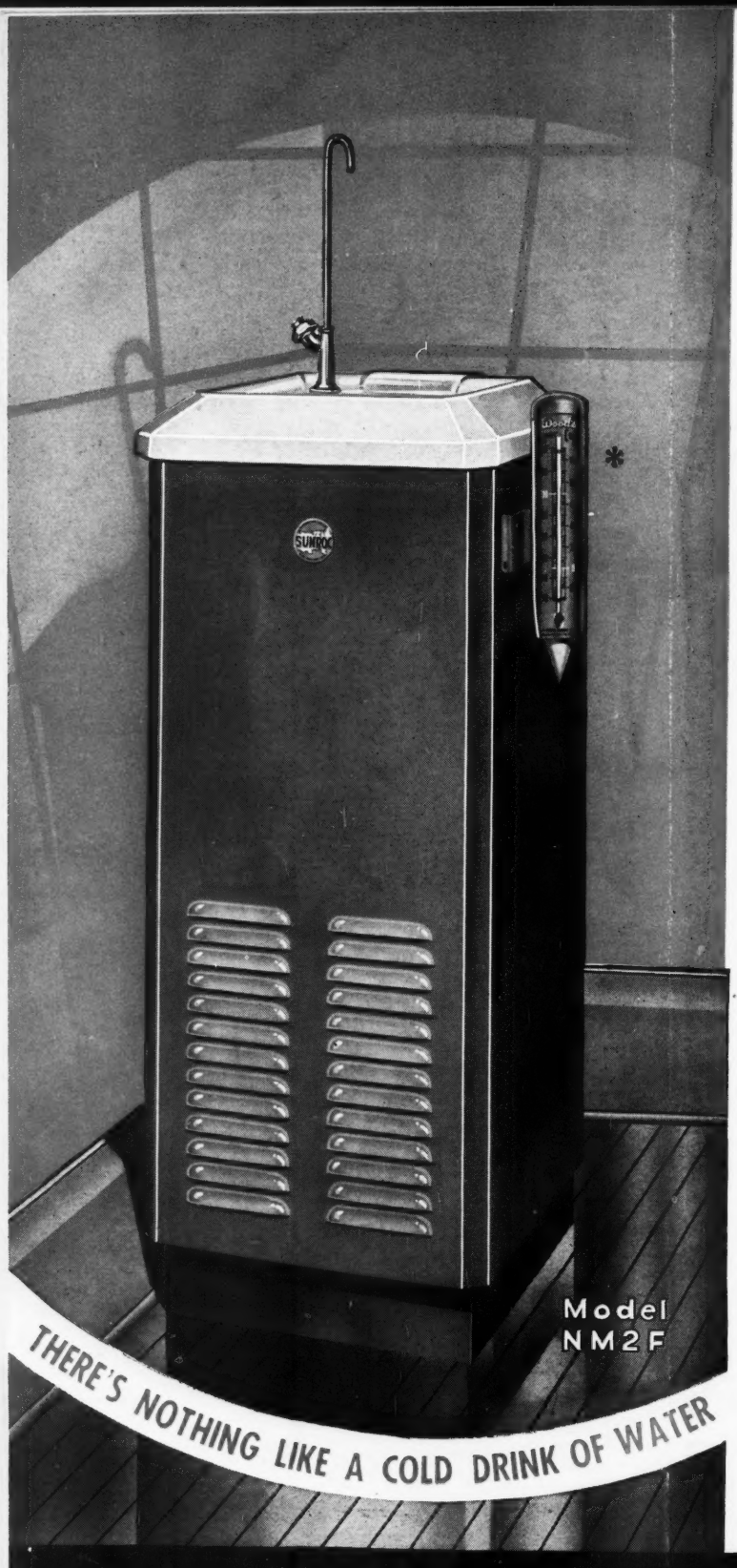
424 ST. HELENE ST.
MONTREAL



NOW!

Cold drinking water wherever and whenever you want it

SUNROC

ELECTRIC WATER COOLER

MODEL NM2F

- **Centralized cold drinking water saves time**
- **Ten gallon capacity each hour**
- **Streamlined attractive cabinet**
- **White vitreous china top**
- **Rugged, efficient and dependable**
- **Cold water at low cost**
- **25 cycle, 60 cycle or Direct Current**

Sunroc Coolers for installation wherever people work, play or congregate.

* The new Deluxe paper cup dispenser complete with built-in, clear vision 9½" thermometer, supplied with each Sunroc cooler on request.

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MONTREAL TORONTO VANCOUVER

Branches throughout Canada